STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155389	A. BUILDING -- B. WING	10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(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: 10/20/22 Facility Number: 000473 Provider Number: 155389 AIM Number: 100290410 At this Emergency Preparedness survey, Westpark A Waters Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 89 certified beds. At the time of the survey, the census was 25. Quality Review completed on 10/25/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	The following Plan of Correction constitutes the facility's written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission to and does not constitute an agreement with alleged deficiencies herein. The Plan of Correction is submitted to meet the requirements established by the state and federal regulations. The facility requests a desk review.	
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)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kesha LaGrone	HFA	11/04/2022

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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	(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 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			

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	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. (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			

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	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, observation 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: Based on record review with the Director of Maintenance from 10:00 a.m. to 12:00 p.m. on 10/20/22, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's 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 propane fired emergency generator and agreed documentation of available load testing for four hours within the most recent three year period was not available for review. Based on observations with the Director of Maintenance during a tour of the facility from 12:00 p.m. to 1:15 p.m. on 10/20/22, the facility has one propane fired emergency generator located outside the building near the north exit door set. Manufacturer's nameplate rating for the generator stated it was rated at 20 kW. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference.	E 0041	**E041**– It is the intent of the facility to ensure 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) to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. The following will be completed by 11/25/22 the Certified Generator Contractor/Maintenance Supervisor conducted the thirty six month period emergency generator test for four continuous hours and documented the results in the facilities Life Safety Binder to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On _10/21/22 the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that a thirty -six month period emergency	11/25/2022

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			generator test for four continuous hours must be conducted on the facilities emergency generator every three years to meet set standards. b. The Maintenance Supervisor/designee will ensure a thirty -six month period emergency generator test for four continuous hours is conducted every three years and documented in the life safety binder to meet set standards. c. The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. At least annually to ensure compliance, the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction**	

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			constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is _____11/25/22_____.	
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: 10/20/22 Facility Number: 000473 Provider Number: 155389 AIM Number: 100290410 At this Life Safety Code survey, Westpark A Waters Community 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 consisted of two sections: the original section determined to be Type III (200) construction and an addition, built in 2003 was determined to be Type V (000) construction. The facility is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The entire facility was surveyed as Type V (000)	K 0000	The following Plan of Correction constitutes the facility's written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission to and does not constitute an agreement with alleged deficiencies herein. The Plan of Correction is submitted to meet the requirements established by the state and federal regulations. The facility requests a desk review.	

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	construction. The facility has a capacity of 89 and had a census of 25 at the time of this visit. All areas where the residents have customary access were sprinklered. The facility has two detached storage sheds which were not sprinklered. Quality Review completed on 10/25/22			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors to the east dining room would self close per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the east dining room. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:00 p.m. to 1:15 p.m. on 10/20/22, the corridor door to the east dining room was held in the fully open position with a magnetic hold open device set to release with fire alarm system activation, latching hardware and a self closing device but the door failed to latch into the door frame when	K 0100	**K100**– It is the intent of the facility to ensure corridor doors to the east dining room would self- close per 4.6.12.3 and to ensure corridor door sets would self -close and latch into the door frame per 4.6.12.3 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On _10/21/22_ the Maintenance Supervisor/designee made repairs to the door to the east dining room to ensure the door fully self closes and latches into the door frame to meet set standards. The Administrator verified the work on __11/4/22. b. On __10/21/22_ the Maintenance Supervisor/designee made repairs to the door on the	11/25/2022

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	tested to self close multiple times. The door failed to fully self close and latch into the door frame because the face of the door on the door handle side kept hitting the door frame neat the top of the door. Based on interview at the time of the observations, the Director of Maintenance agreed the corridor door to the east dining room did not self close and latch into the door frame when tested to self close multiple times. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 4 corridor door sets would self close and latch into the door frame per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the corridor door set by Room 6. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:00 p.m. to 1:15 p.m. on 10/20/22, the west door in the corridor door set by Room 6 was held in the fully open position with a magnetic hold open device set to release with fire alarm system activation, latching hardware and a self closing device but the door failed to self close and latch into the door frame when tested to close multiple times. The top of the door kept hitting the door frame and would not fully self close and latch into the door frame. Based on interview at the time of		west door in the corridor door set by Room 6 to ensure it fully self closes and latches into the door frame to meet set standards. The Administrator verified the work on __11/4/22_ . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On __10/21/22__ the Maintenance Supervisor/designee inspected all corridor doors throughout the facility and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On ___10/21/22____ the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that corridor doors must fully self- close and latch into the frame to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure they fully self-close and latch into the frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.	

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	the observations, the Director of Maintenance agreed the west door in the door set would not fully self close and latch into the door frame. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is ___11/25/22_____.**	
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			

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	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. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS			

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	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 1 of 8 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 using the East Alcove exit door by Room 41. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:00 p.m. to 1:15 p.m. on 10/20/22, the exit door to the outside of the facility in the East Alcove by Room 41 was marked as a facility exit with an exit sign and could be opened by entering a code into a keypad at the door set. However, the keypad had no electrical power and was not operable.	K 0222	**K222 -** It is the intent of the facility to ensure means of egress through exits are readily accessible for residents without a clinical diagnosis requiring specialized security measures to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On _____10/21/22____ a Certified Contractor/Maintenance Supervisor replaced the keypad on the exit door to the outside of the facility in the East Alcove by Room 41 to meet set standards. The Administrator verified the posting of the codes on __11/4/22____ . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On ____10/21/22___ the Maintenance Supervisor/designee inspected all	11/25/2022

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	The exit door could not be opened without electrical power for the keypad. Based on interview at the time of the observations, the Director of Maintenance stated the keypad was not operable and a replacement keypad was on order. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		doors to the means of egress to ensure they were readily accessible for use and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On _____10/21/22____ the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that doors must be readily accessible for use to meet set standards. b. Maintenance Supervisor/designee will inspect all means of egress throughout the facility weekly to ensure doors are readily accessible for use as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is ___11/25/22___.**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A			

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	155389	A. BUILDING 01 B. WING	10/20/2022

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	a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) 1. Based on observation and interview, the facility failed to ensure 1 of over 8 hazardous areas such as 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 20 residents, staff and visitors in the vicinity of the Laundry Room. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:00 p.m. to 1:15 p.m. on 10/20/22, a one half inch in diameter hole was noted above the door handle for the corridor door to the Laundry Room by the southeast exit door for the facility. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned hazardous area corridor door would not resist the passage of smoke. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)	K 0321	**K321**– It is the intent of the facility to ensure hazardous areas such as laundries are separated from other spaces by smoke resistant partitions and doors and ensure hazardous areas such as combustible storage rooms over 50 square feet in size are separated from other spaces by smoke resistant partitions and doors to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On ___11/4/22_____ the Maintenance Supervisor/designee repaired the one- half inch in diameter hole above the door handle for the corridor door to the Laundry Room by the southeast exit door with a 1 hour fire rated material to meet set standards. The Administrator verified the work on ___11/4/22_____ . b. The following will be completed by 11/25/22____ the Maintenance Supervisor/designee installed a self- closure on the door to resident room 46 that has been converted to a storage room	11/25/2022

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	2. Based on observation and interview, the facility failed to ensure 1 of over 8 hazardous areas such as combustible storage rooms over 50 square feet in size were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 46. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:00 p.m. to 1:15 p.m. on 10/20/22, resident sleeping Room 46 had been converted to a storage room for combustible boxes and supplies which filled the room. The corridor door to Room 46 was not self closing or automatic closing. Based on interview at the time of the observations, the Director of Maintenance agreed the corridor door to the aforementioned hazardous area was not self closing or automatic closing. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		for combustible boxes and supplies to meet set standards. The Administrator verified the work on ____11/25/22____ . **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On _____11/4/22_____ the Maintenance Supervisor/designee inspected all hazardous areas for holes and self-closing devices and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On ___10/21/22_____ the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that all hazardous areas remain free of holes/penetrations and must have self-closing devices to meet set standards. b. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly to ensure they remain free of holes/penetrations and have self-closing devices as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.	

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			c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is ____11/25/22_____.**	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code.			

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	Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Table 14.4.5 at 15(a) states duct detectors shall be functional tested annually. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm System Inspection" documentation dated 01/07/22 and 07/01/22 with the Director of Maintenance during record review from 10:00 a.m. to 12:00 p.m. on 10/20/22, functional testing documentation and semi-annual visual inspection documentation for fire alarm system duct detectors in the facility within the most recent twelve month period was not available for review. The 01/07/22 and 07/01/22 fire alarm system inspection and testing documentation did not include duct detectors. Based on interview at the time of record review,	K 0345	**K345**– It is the intent of the facility to ensure alarm systems are maintained in accordance with 9.6.1.3 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: ` The following will be completed by 11/25/22_____ a licensed fire alarm contractor/designee conducted the functional testing and the semi-annual visual inspection of the duct detectors and retained documentation in the facilities Life Safety Binder to meet set standards. The Administrator verified the work on _____11/25/22____ . 1. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 2. **MEASURES TO PREVENT REOCCURRENCE**: a. On ___10/21/22____ the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that alarm systems must be maintained in accordance with 9.6.1.3 and functional testing and semi-annual visual inspections on the duct detectors must be performed to meet set standards. b. Maintenance Supervisor/designee will ensure	11/25/2022

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	the Director of Maintenance stated additional fire alarm inspection documentation for the most recent twelve month period was not available for review and agreed duct detector inspection and testing documentation for 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 12:00 p.m. to 1:15 p.m. on 10/20/22, one duct detector was noted in HVAC ductwork in the closet by the southwest exit door of the facility and one duct detector was also noted in HVAC ductwork in the closet by the northwest nurse's station. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		alarm systems are maintained and functional testing and semi-annual visual inspections on the duct detectors are performed as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 3. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.**	

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			Our date of compliance is ____11/25/22_____.	
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 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 record review, observation and interview; the facility failed to ensure corridor walls in 1 of 5 smoke compartments were constructed to resist the transfer of smoke. LSC 8.3.3.1 states fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage and sills shall be in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Openings Protectives. NFPA 80, 2010 Edition, Section	K 0362	**K362** – It is the intent of the facility to ensure corridor walls in smoke compartments are constructed to resist the transfer of smoke to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. The following will be completed by 11/25/22_____ a licensed contractor made the	11/25/2022

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	4.8.2.11 states for service counter fire doors, sills shall be provided as part of the fire door assembly. Section 4.8.2.2 states sills shall be constructed of noncombustible materials. Section 4.8.2.5 states for special-purpose horizontally sliding accordion or folding doors with frames having a jamb depth of 4 inches or less, the sill width shall be equal to the jamb depth. Section 5.2.5.2 states no open holes or breaks shall exist in surfaces of either the door or frame. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the east dining room. Findings include: Based on review of the rolling fire door inspection contractor's "Work Order #111692" documentation dated 07/01/22 with the Director of Maintenance during record review from 10:00 a.m. to 12:00 p.m. on 10/20/22, the kitchen has two rolling fire doors with both windows needing a fire resistant threshold which have no gaps when closed. The 07/01/22 work order documentation stated "both windows need a fire resistant threshold and have gaps in the bottom corners when closed". In addition, review of "Invoice #i95977" documentation dated 07/05/22 also stated "both windows need a fire resistant threshold and have gaps in the bottom corners when closed". Based on interview at the time of record review, the Director of Maintenance stated they don't use the main roll down door that much, the inspection contractor has not been back to the facility since the 07/01/22 inspection and stated parts may be on order. Based on observations with the Director of Maintenance during a tour of the facility from 12:00 p.m. to 1:15 p.m. on 10/20/22, the east dining room was open to the corridor. Both rolling fire doors for the kitchen are in the north wall of the east dining room. The main roll		necessary repairs to the two rolling fire doors for the kitchen in the north wall of the east dining room to ensure no gaps to meet set standards. The Administrator verified the repair on ____11/25/22____ . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The facility only has two rolling doors. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On _10/21/22_____ the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that all fire doors must remain free of gaps to resist the transfer of smoke to meet set standards. b. Maintenance Supervisor/designee will inspect all fire doors to ensure they remain free of gaps as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance	

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	door was in the fully open position during lunchtime. After lunch, the door was in the fully closed position and gaps were noted in the corners of both rolling doors near the bottom sill for the doors when each door was in the fully closed position. Based on interview at the time of the observations, the Director of Maintenance agreed both rolling fire doors had gaps in the corners of the doors when each door was in the fully closed position. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/25/22_____.**	
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			

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	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 4 of over 40 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during the initial walk through of the	K 0363	**K363** – It is the intent of the facility to ensure corridor doors have no impediment to closing and latching into the door frame and would resist the passage of smoke to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On _____10/21/22___ the Maintenance Supervisor/designee removed the red chair from the	11/25/2022

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	facility from 9:30 a.m. to 9:45 a.m. on 10/20/22, the corridor door to the Breakroom by the northwest nurse's station was propped in the fully open position with a red chair. Based on observation at 12:18 p.m. on 10/20/22, the corridor door to the Breakroom was still propped in the fully open position with the red chair. Based on observations with the Director of Maintenance during a tour of the facility from 12:00 p.m. to 1:15 p.m. on 10/20/22, the following was noted: a. a wedge was placed on the floor under the corridor door to the Scheduler/Medical Records office by Room 10 to prop the door in the fully open position. b. a one half inch in diameter hole was noted above the door handle for the corridor door to the Janitor's Closet by the Nourishment Pantry. c. a one half inch in diameter hole was noted above the door handle for the corridor door to the Laundry Room by the southeast exit door for the facility. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned corridor doors had an impediment to closing and latching into the door frame and would not resist the passage of smoke. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		corridor door to the breakroom by the northwest nurse's station and A) removed the wedge on the floor under the corridor door to the scheduler/medical records office by room 10, B) repaired the half inch in diameter hole above the door handle for the corridor door to the Janitor's closet by the nourishment pantry with a 1 hour fire rated material and C) repaired the half inch in diameter hold noted above the door handle for the corridor door to the laundry room by the southeast exit door with a 1 hour fire rated material to meet set standards. The Administrator verified the work on ____11/4/22____ . **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all corridor doors for impediments to closing and free of holes and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On ____10/21/22____ the Administrator in-serviced the Maintenance Supervisor/designee and all staff on the requirement that corridor doors may not have impediments to closing and must remain free of holes to meet set standards. b. Maintenance	

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			Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure there are no impediments to closing and they remain free of holes as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			all regulatory requirements. Our date of compliance is _____11/25/22_____.	
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 1 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 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 northwest	K 0372	**K372 -**It is the intent of the facility to ensure openings through ceiling smoke barriers are protected to maintain the fire resistance rating of the smoke barrier to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On ___11/4/22___ the Maintenance Supervisor/designee repaired the hole around a ceiling mounted sprinkler in the closet by the Breakroom by the northwest nurse's station with a one- hour fire rated material to meet set standards. The Administrator verified the repair on ____11/4/22___ .	11/25/2022

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	nurse's station. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:00 p.m. to 1:15 p.m. on 10/20/22, a two inch in diameter hole around a ceiling mounted sprinkler was noted in the closet by the Breakroom by the northwest nurse's station and exposed the attic above. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned hole 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 Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On ___10/21/22_____ the Maintenance Supervisor/designee inspected all smoke barrier walls & ceilings throughout the facility for penetrations and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On ____10/21/22___ the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that smoke barrier walls & ceilings must be free of penetrations and voids to meet set standards. b. Maintenance Supervisor/designee will inspect all smoke barrier walls & ceilings throughout the facility monthly for penetrations and voids as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	

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			4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is ___11/25/22_____.**	
K 0761 SS=E Bldg. 01	1. 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 of 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	K 0761	**K761** – It is the intent of the facility to ensure annual inspection and testing of all fire door assemblies are completed in accordance of LSC 19.1.1.4.1.1 and to ensure proper operation is maintained for rolling steel fire doors in accordance with NFPA 80 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On ____11/4/22_____ the	11/25/2022

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	accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. 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, Section 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 full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or		Maintenance Supervisor/designee conducted the annual inspection of the fire door assemblies for the oxygen storage and transfilling room and documented those inspection results on the Annual Door Inspections log to meet set standards. The Administrator verified the inspections and documentation on _____11/4/22_____ . b. The following will be completed by 11/25/22_____ the licensed contractor/Maintenance Supervisor made the necessary repairs to the serving window roll door to ensure it operates correctly with activation of the fire alarm meet set standards. The Administrator verified the inspections and documentation on _____11/25/22__ . 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On ___11/4/22_____ the Administrator/corporate Property Manager inserviced the Maintenance Supervisor/designee on the requirement that annual testing & inspections of fire rated doors including the oxygen storage and transfilling room must be conducted to ensure proper operation and documented on the Annual Door Inspections log and	

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	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 over 20 residents, staff and visitors in the vicinity of the oxygen storage room by the northeast nurse's station. Findings include: Based on review of "Annual Inspection of Swinging Fire Door Assemblies" documentation dated 05/17/22 with the Director of Maintenance during record review from 10:00 a.m. to 12:00 p.m. on 10/20/22, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period did not include doors to the oxygen storage and transfilling room. Based on interview at the time of record review, the Director of Maintenance was unsure if the 05/17/22 fire door inspection documentation included doors to oxygen storage and transfilling rooms and agreed additional fire door inspection documentation for 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 12:00 p.m. to 1:15 p.m. on 10/20/22, the corridor door to the oxygen storage and transfilling room by the northeast nurse's station was a fire-rated door with a 1-hour fire resistance rating label affixed to the hinge side of the door. Four liquid oxygen containers and nineteen 'E' type oxygen cylinders were stored in the room. This finding was reviewed with the Administrator and the Director of Maintenance during the exit		maintained at the facility to meet set standards. b. Maintenance Supervisor/designee will conduct the annual door inspections to ensure proper operation and document the inspection results on the Annual Door Inspection log as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

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	conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure proper operation was maintained for 1 of 2 rolling steel fire doors in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 2010 Edition, the Standard for Fire Doors and Other Opening Protectives, Section 11.4.1.1 requires an automatic-closing device shall be installed on every rolling steel door. Section 11.4.1.2 states rolling steel doors shall close automatically upon activation or release of a fusible link or detector. Section 11.4.2.2.1 states after the automatic closing is activated, the door shall remain in the closed position until the automatic-closing device has been reset. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the east dining room. Findings include: Based on review of the rolling fire door inspection contractor's "Work Order #111692" documentation dated 07/01/22 with the Director of Maintenance during record review from 10:00 a.m. to 12:00 p.m. on 10/20/22, the kitchen has two rolling fire doors. The 07/01/22 work order documentation stated "Performed annual roll door inspection. The dish window operated correctly but the serving window did not drop with the fire		**This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is ____11/25/22_____.**	

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	alarm". In addition, review of "Invoice #i95977" documentation dated 07/05/22 also stated "Performed annual roll door inspection. The dish window operated correctly but the serving window did not drop with the fire alarm". Based on interview at the time of record review, the Director of Maintenance stated they don't use the main roll down door that much, the inspection contractor has not been back to the facility since the 07/01/22 inspection and stated parts may be on order. Based on observations with the Director of Maintenance during a tour of the facility from 12:00 p.m. to 1:15 p.m. on 10/20/22, the east dining room was open to the corridor. Both rolling fire doors for the kitchen are in the north wall of the east dining room. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 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			

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	once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review, observation and interview; the facility failed to document 36 month period emergency generator testing for 1 of 1 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	K 0918	**K918** – It is the intent of the facility to ensure to document 36-month period emergency generator testing for emergency generators in accordance with NFPA 99 & NFPA 110 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. The following will be completed by 11/25/22_____ the Licensed generator contractor/Maintenance Supervisor conducted the thirty six month period emergency generator test for four continuous hours and documented the results in the facilities Life Safety Binder to	11/25/2022

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	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 10:00 a.m. to 12:00 p.m. on 10/20/22, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's 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 propane fired emergency generator and agreed documentation of available load testing for four hours within the most recent three year period was not available for review. Based on observations with the Director of Maintenance during a tour of the facility from 12:00 p.m. to 1:15 p.m. on 10/20/22, the facility has one propane fired emergency generator located outside the building near the north exit door set. Manufacturer's nameplate rating for the generator stated it was rated at 20 kW. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On ___10/21/22_____ the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that a thirty -six month period emergency generator test for four continuous hours is required to meet set standards. b. The Maintenance Supervisor/designee will ensure a thirty- six month period emergency generator test for four continuous hours is conducted every three years and documented in the life safety binder to meet set standards. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance	

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			Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is ___11/25/22____.**	