STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING -- B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/03/24 Facility Number: 003075 Provider Number: 155695 AIM Number: 200364160 At this Emergency Preparedness survey, Riverside Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 97 certified beds. At the time of the survey, the census was 76. Quality Review completed on 01/04/24	E 0000	**K000** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/03/24 Facility Number: 003075 Provider Number: 155695 AIM Number: 200364160 At this Life Safety Code survey, Riverside Village was found not in compliance with Requirements	K 0000	**K000** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Greg Schiavone		01/19/2024

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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	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 with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke alarms were installed in the resident rooms. The building is fully protected by a 250 kW diesel powered emergency generator. The facility has a capacity of 97 and had a census of 76 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except a detached shed used for storage. Quality Review completed on 01/04/24			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 5 corridor means of egresses were continuously maintained free of obstructions by ensuring the exit door contained working panic	K 0211	**K211**	01/26/2024

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	hardware. LSC 7.2.1.5.12 stated devices shall not be installed in connection with any door assembly on which panic hardware or fire exit hardware is required where such devices prevent or are intended to prevent the free use of the leaf for purposes of egress, unless otherwise provided in 7.2.1.6. This deficient practice affects approximately 20 residents and staff. Findings include: Based on observation during a tour of the facility with the Administrator on 01/03/24 between 12:40 p.m. and 3:15 p.m., the set of emergency exit door sets next to room 101 opened, however the right door would not open when tested. The door was tested by the Surveyor and the Administrator four times. Based on an interview at the time of observation, the confirmed that one of the doors opened, however the right door would not open due to the latching mechanism needed repaired for it to work properly. Findings were discussed with the Administrator at exit conference. 3.1-19(b)		The facility requests paper compliance **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Door next to room 101 has been serviced and it is in proper working condition. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All means of egress were inspected. No other obstruction or impediments were found. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance staff were educated to ensure all means of egress are free from obstructions or impediments. **• how the corrective action(s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance program will be put into place; and The Executive Director will round with the maintenance director prior to the compliance date to ensure all means of egress are free from obstructions or impediments. This has been added to the monthly PM log to be completed by the maintenance director. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed.	
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic closing. In addition, NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 40 residents in 3 smoke compartments.	K 0226	**K226** The facility requests paper compliance **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Door next to room 410 has been serviced and it is in proper working condition.	01/26/2024

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	Findings include: Based on observations with the Administrator on 01/03/24 at 12:33 p.m., the 3-hour rated fire door set by room 410 was used as horizontal exit and as smoke barrier. When tested, the doors failed to latch into the frame after testing three times. Based on interview at the time of observation, the Administrator agreed that the doors would not fully close and latch due to the latching devices of the doors being stuck which leaves the partially open. The finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		**how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All horizontal exit fire doors were inspected. No other concerns were found. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance staff were educated to ensure horizontal exit fire doors automatically close and latch **• how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Executive Director will round with the maintenance director prior to the compliance date to ensure all horizontal exit fire doors automatically close and latch. This has been added to the monthly PM log to be completed by the maintenance director. The Executive Director will review the	

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			preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 1. Based on observation and interview, the facility failed to ensure 1 of 5 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observation with the Administrator on 01/03/24 between 09:33 a.m. and 12:33 p.m., the battery-operated emergency light outside of exit door by room 101 did not work when tested. Based on interview at the time of the observations, the Administrator agreed the battery-operated emergency light failed to function when its respective test button was pushed.	K 0291	**K291** The facility requests paper compliance. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1. New batteries were installed on the faulty battery-operated emergency lights and tested for proper function. The emergency light by room 101 is in proper working condition. 2. An itemized record of the light testing will be completed by 1.26.2024 **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	01/26/2024

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	The findings were reviewed with the Administrator during the exit conference. 3.1-19(b) 2. Based on records review and interview, the facility failed to maintain itemized records of the inspections and tests for 5 of 5 battery backup lights. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Administrator on 01/03/24 between 09:33 a.m. and 12:33 p.m., the "Emergency Lighting Battery Test" form indicated the battery operated lights were tested monthly and annual but the form was not itemized to show that each emergency light in the facility was tested. The list only listed that "all facility passed". Forms prior to 04/2023 were properly itemized and indicated that each one passed, however after were improperly listed. Based on an interview at the time of record review, the Administrator agreed that the most recent forms were not itemized. This finding was reviewed with the Administrator at the exit conference.		1. All other battery-operated emergency lights were tested with no concerns noted. 2. An itemized record of the light testing will be completed by 1.26.2024 **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The maintenance director was educated on testing of battery-operated emergency lights and itemization of testing records **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Executive Director will round with the maintenance director prior to the compliance date to ensure all battery-operated emergency lights are maintained and functioning properly and that the records are properly itemized. This has been added to the monthly PM log to be completed by the maintenance director. The Executive Director will review the preventative maintenance checks performed by the maintenance	

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	3.1-19(b)		director monthly and sign off that the checks were completed.	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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. Based on observation, record review and interview, the facility failed to ensure 18 of 48 battery operated smoke alarms installed in resident sleeping rooms were not over ten years old in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over approximately 30 residents and staff. Findings include: Based on record review with the Administrator on 01/13/24 between 09:33 a.m. and 12:33 p.m., the battery-smoke detector testing documentation titled "Detectors: Test battery-operated smoke detectors" dated 12/29/23 indicated that 18 smoke detectors failed due to them being older than 10 years since their manufacturing date. Based on observation during a tour of the facility between 12:40 p.m. and 3:15 p.m., the battery smoke	K 0300	**K300** The facility requests paper compliance. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** All 18 battery powered smoke detectors were replaced. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All other battery powered smoke detectors were inspected with no other concerns noted.	01/26/2024

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	detectors in the following rooms were over 10 years old respectively: a) Room 102, 114 and 306 had a date of 03/12/12 b) Room 204 had a date of 04/16/13 c) Room 400 had a date of 09/17/12 d) Room 402 had a date of 03/07/13 The rooms listed above had some of the battery smoke detectors that had failed on the testing sheet. Based on interview at the time of record review, the Administrator stated that he was unaware if all the failed smoke detectors had been replaced due to a change in maintenance personnel. He later confirmed that the smoke detectors pulled were all over 10 years old. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)		**what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The maintenance director was educated on battery powered smoke detector inspection and maintenance. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Executive Director will round with the maintenance director prior to the compliance date to ensure all battery powered smoke detectors are not expired and functioning properly. This has been added to the monthly PM log to be completed by the maintenance director. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed.	
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained			

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	in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 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, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator on 01/03/24 between 09:33 a.m. and 12:33 p.m., sensitivity testing dated 04/26/22 titled "Fire Alarm Supplementary Form" indicated that "devices in areas under COVID quarantine were not inspected/tested. IT IS THE RESPONSIBILITY OF FACILITY TO CONTACT IEI SO WE CAN RETURN TO INSPECT DEVICES." Upon further review, 32 smoke detectors throughout the facility had not received sensitivity testing due to the aforementioned issue. Upon further investigation, sensitivity	K 0345	**K345** The facility requests paper compliance. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The sensitivity testing has been completed. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All inspection reports have been reviewed for possible missing items. No other concerns have been identified. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** The maintenance director was	01/26/2024

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	testing was not recorded on dates 10/19/22 and 04/25/23. It was undetermined whether the 32 smoke detectors have had sensitivity testing within the past two years. Based on interview at the time of record review, the Administrator stated he was unsure if the rest of the untested smoke detectors received sensitivity testing. Later during the survey, the Administrator was able to contact the alarm company and they confirmed that the untested smoke detectors never received inspection and were overdue for sensitivity testing. The Administrator later acknowledged the aforementioned issues. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		educated on maintaining the fire alarm system, including sensitivity testing every two years. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Executive Director will round with the maintenance director prior to the compliance date to ensure all inspection records have been reviewed. This has been added to the monthly PM log to be completed by the maintenance director. The Executive Director will review inspection records with the maintenance director as inspections are completed.	
K 0363 SS=F Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain			

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	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.			
	1. Based on observation and interview, the facility failed to ensure 5 of 45 resident room corridor doors on the southwest wing were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in room 406. Findings include: Based on observation with the Administrator on 01/03/24 between 12:40 p.m. and 3:15 p.m., the corridor doors to resident rooms 113, 101, 206, and 400 did not latch into the frame when tested three	K 0363	**K363** The facility requests paper compliance. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1. Door in rooms 101, 113, 206, 400, and 406 have been adjusted and are functioning properly at this time.	01/26/2024

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	times. Furthermore, the double door set to the linen closet did not latch into the frame. The inactive leaf of the door set had self-latching hardware, but could only be manually latched as to the self-latching hardware was not working. Based on interview at the time of observations, the Administrator confirmed that all the doors did not latch after testing multiple times. He further stated that the doors would have to be adjusted. The finding was reviewed with the Administrator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 5 of 45 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observation with the Administrator on 01/03/24 from 12:40 p.m. to 3:15 p.m., the corridor resident room doors to rooms 407, 405, 403, 302, and 206 were propped open with trash cans. Based on interview at the time of observation, the Administrator acknowledged the aforementioned corridor doors would not close unless the trash cans were move first. Findings were discussed with the Administrator at exit conference. 3.1-19(b)		2. Trash can obstructions have been removed **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All resident room doors have been inspected with no other issues identified. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** 1. The maintenance director was educated to ensure resident doors are latching properly. 2. All staff will be educated keeping doors free of obstructions **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Executive Director will round with the maintenance director prior to the compliance date to ensure all corridor doors are functioning properly and are free of obstructions. This has been	

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	155695	A. BUILDING 01 B. WING	01/03/2024

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			added to the monthly PM log to be completed by the maintenance director. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed.	
K 0500 SS=C Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services 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. Based on observation and interview, the facility failed to ensure 5 of 5 fuel-fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect approximately all residents and staff. Findings include: Based on observation during a tour of the facility with the Administrator on 01/03/24 between 12:40 p.m. and 3:15 p.m., five fuel-fired water heaters were located throughout in the facility in the basement and on the main floor storage rooms. Based on record review with the Administrator between 09:33 a.m. and 12:33 p.m., the five water	K 0500	**K500** The facility requests paper compliance. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The devices were inspected on 1.16.2023 with no issues noted. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**	01/26/2024

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	heater permits presented had an expiration date of 10/05/23. An email chain was presented to the surveyor during record review that indicated it had has its inspection, however two water heaters failed their inspection and certificates were not granted until the deficiencies were fixed. Upon interview with the Administrator, he indicated that the repairs the inspector found had been repaired, however he was waiting for a reinspection by the inspector. Emails were provided to the surveyor indicated a follow-up was done with the boiler/heater inspector. The Administrator confirmed that the water heater certificates were still expired. Findings were discussed with the Administrator at exit conference. 3.1-19(b)		No other concerns have been identified. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Maintenance Director educated to ensure all inspection records for boilers are completed. The facility will acquire the inspection certificates from the state of Indiana as they become available. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Executive Director will round with the maintenance director prior to the compliance date to ensure all boiler inspection have been completed and documentation in place. This has been added to the monthly PM log to be completed by the maintenance director. The Executive Director will review inspection records with the maintenance director as inspections are completed.	

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical panel in the 300/400 hall was secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are 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 approximately 10 staff and residents. Findings include: Based on observation with Administrator on 01/03/24 between 12:40 p.m. and 2:33 p.m., the electrical panel in the 300/400 hall, across from the nurses station, was unlocked when tested. The panel included breakers to the lights and outlets in the therapy gym lights, range, and receptacles. Based on interview at the time of observation, the Administrator stated the electrical panel should	K 0511	**K511** The facility requests paper compliance. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The electric panel has been locked and secured. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All other electric panels were checked with no concerns identified. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**	01/26/2024

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	have been locked, but he did not have access to keys to relock the panel. Findings were discussed with the Administrator at exit conference. 3.1-19(b)		The maintenance director was educated to ensure the electric panels are secured. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Executive Director will round with the maintenance director prior to the compliance date to ensure all electric panels are properly secured. This has been added to the monthly PM log to be completed by the maintenance director. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.			

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	19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Administrator on 01/03/24 between 09:33 a.m. and 12:33 p.m., no documentation was available to show a third shift fire drill for the third quarter of 2023 was conducted. Two fire drills were indicated they were a designated third shift, however the times they were conducted were within the second shift time frame. Based on interview at the time of record review, the Administrator stated that a fire drill could have been conducted, however they were unsure where the documentation could be because documentation could not be found during the survey. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	**K712** **The facility requests paper compliance.** **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The facility has performed a fire drill on all 3 shifts. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** The facility will continue to perform fire drills monthly on alternating shifts and times. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** The maintenance director was educated on the requirements of fire drill testing. The maintenance director/designee will complete a fire drill monthly, alternating shifts each month. **how the corrective action(s) will be monitored to**	01/26/2024

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			ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Executive Director will verify with the maintenance director prior to the compliance date that all three shifts have had a fire drill completed. This has been added to the monthly PM log to be completed by the maintenance director. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the fire drills were completed.	