STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155616	A. BUILDING -- B. WING	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NEW ALBANY NURSING AND REHABILITATION CENTER	201 E ELM ST NEW ALBANY, IN 47150

(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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/09/19 Facility Number: 001145 Provider Number: 155616 AIM Number: 200120200 At this Emergency Preparedness survey, New Albany Nursing and Rehabilitation Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a total of 143 licensed beds with 122 certified beds. At the time of the survey, the total census was 97. Quality Review completed on 07/22/19	E 0000	Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction be considered the allegation of compliance effective 8-8-19.	
E 0015 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C)	E 0015	E015 The facility has policies and procedures to ensure subsistence needs for staff and residents in the event of evacuation or shelter in place include but are not limited to: (1) Food, water, medical and pharmaceutical supplies; and, (2) alternate sources of energy to maintain temperatures, emergency lighting, fire detection,	08/03/2019

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

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	Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency/Disaster Manual on 07/09/19 between 9:40 a.m. and 11:40 a.m. with the Administrator present, the plan provided did not address the loss of sewage and waste disposal in an emergency. Based on interview at the time of records review, the Administrator agreed the plan did not address the loss of sewage and waste disposal in an emergency.		suppression and alarm systems, and sewage and waste disposal. The deficient practice affects all residents and will be corrected as noted. The policies and procedures to ensure subsistence needs in the event of evacuation or shelter in place, including sewage and waste water disposal, were updated, reviewed and approved by the Interdisciplinary team (IDT) on 8-7-19. The interdisciplinary team was inserviced the same date on subsistence needs including sewage and waste disposal. All staff will be inserviced annually. The administrator will review the policies and procedures ensuring subsistence needs for staff and residents in the event of evacuation or shelter in place, including sewage and waste disposal monthly for six months and annually to ensure compliance. The review and any updates will be documented. The results of the monthly reviews will be taken to the QAPI Committee meeting, overseen by the administrator and reviewed by corporate risk management. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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E 0032 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c)(3). This deficient practice could affect all occupants. Finding include: Based on review of the Emergency/Disaster Manual on 07/09/19 between 9:40 a.m. and 11:40 a.m. with the Administrator present, the emergency preparedness communication plan failed to include a primary and an alternate means for communication. Based on interview at the time of record review the Administrator confirmed the facility does not have a plan for primary and alternative means for communication.	E 0032	E032 The facility emergency preparedness communication plan includes primary and alternate means for communicating with Federal, State, regional and local emergency management agencies. The deficient practice affects all residents and will be corrected as noted. The facility emergency preparedness communication plan with primary and alternate means for communicating with Federal, State, regional and local emergency management agencies, was updated, reviewed and approved by the Interdisciplinary team (IDT) on 8-7-19. The interdisciplinary team was inserviced the same date on the need for primary and alternate means of communication in an emergency. All staff will be inserviced annually. The administrator will review the communication plan monthly for six months and annually to ensure compliance. The review and any updates will be documented. The results of the monthly reviews will be taken to the QAPI Committee meeting, overseen by the	08/03/2019

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			administrator and reviewed by corporate risk management. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
E 0039 SS=C Bldg. --	Based on record review and interview, the facility failed to provide documentation of an analysis of the facility's response to exercises conducted to test the emergency plan. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include:	E 0039	E039 The facility conducted an inservice for the Interdisciplinary Team on 8-7-19 regarding analyzing and documenting the facility's response and performance during annual community-based and or table top exercises as a means of testing the Emergency Operations Plan. The deficient practice affects all residents and will be corrected as noted. To meet the Requirements in 2019, the facility's response and performance during annual full scale community-based and table top exercises will be analyzed and documented to test the Emergency Operations Plan. IDT inserviced on 8-7-19. All staff will be inserviced annually. The analysis of facility response and performance following community-based and table top exercises has been added to the TELS task list as a schedule reminder.	08/03/2019

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	Based on review of the Emergency/Disaster Manual on 07/09/19 between 9:40 a.m. and 11:40 a.m. with the Administrator present, the facility was able to provide documentation of two exercises within the past twelve months, however, the facility was unable to provide an after action report for either exercise. The Administrator said the facility did take part in at least two exercises over the past 12 months, but was did not have an after action report for either.		The administrator will review the documentation of the facility analyses for community-based and table top exercises monthly for six months and annually to ensure compliance. The results of the monthly completion and documentation reviews will be taken to the QAPI Committee meeting, overseen by the administrator and reviewed by corporate risk management. If a threshold of 95% in not achieved an action plan will be developed to ensure compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/09/19 Facility Number: 001145 Provider Number: 155616 AIM Number: 200120200 At this Life Safety Code survey, New Albany Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a partial basement was	K 0000	Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction be considered the allegation of compliance effective 8-8-19.	

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	determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus, the facility has smoke detectors hard wired to the nurses call system with battery back up in all resident sleeping rooms. The facility has a total capacity of 143 licensed beds with 122 certified beds and had a total census of 97 at the time of this visit. The entire facility was surveyed due to the lack of a 2 hour fire-rated separation. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 07/22/19			
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. Based on observation and interview, the facility failed to ensure 2 of 2 doors between the kitchen and AL dining room would close and latch properly per NFPA 101, 2012 edition at 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, as well as staff and visitors while in the AL dining room. Findings include:	K 0100	K100 The door on the left between the AL dining room and kitchen and the door on the right between the AL dining room and the kitchen will be repaired to self-close and latch. All doors with self-closing devices will be inspected and adjustments made if needed.	08/03/2019

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	Based on observations on 07/09/19 at 1:45 p.m. and again at 1:47 p.m. during a tour of the facility with the Maintenance Supervisor, the door on the left between the AL dining room and kitchen was equipped with a self closing device and did not close completely when tested several times. There was a six inch gap between the door and frame when closed fully. Furthermore, the door on the right between the AL dining room and kitchen was also equipped with a self closing device which did not close completely into the door frame. Both of these doors would not closed completely and latch without pushing/pulling with force. Based on interview at the time of observations, the Maintenance Supervisor acknowledged the aforementioned condition of each door and said he was aware of the problems with these two doors and the facility was in the process of correcting the problems with the doors. 3.1-19(b)		The maintenance staff was inserviced on 8-1-19 regarding the operation and inspection of doors with self-closure devices. Doors with self-closing devices will be inspected monthly and integrated into the monthly preventative maintenance program. To ensure compliance, maintenance will monitor doors with self-closing devices weekly for two months and bi-weekly for four months with results documented on a QAPI audit form. Repairs and adjustment will be made immediately if needed. Results will be reviewed at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 95% is not achieved action plans will be revised.	
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 8 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects at least 20 residents, as well as staff and visitors.	K 0211	K211 The metal lift in the corridor outside room 135 was removed immediately so as not to obstruct the continuous means of egress in	08/03/2019

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	Findings include: Based on an observations on 07/09/19 between 11:40 a.m. and 5:10 p.m. during a tour of the facility with the Maintenance Supervisor, there was a metal lift stored in the corridor outside room 135. This metal lift was not provided with wheels. Based on an interview at the time of each observation, the Maintenance Supervisor said the lift was stored in a resident's room but that resident didn't want it in the room any longer. 3.1-19(b)		an emergency. The maintenance person inspected all corridors, exit discharges and locations, to ensure the means of egress is continuously maintained free of all obstructions in case of emergency. Maintenance staff was inserviced on 8-1-19 regarding maintaining corridors and exits free of obstruction to full use in case of emergency. All staff will be inserviced regarding maintaining corridors and exits free of obstruction to full use in case of emergency including removing obstructions immediately. Maintenance will make weekly rounds to ensure the corridors and exits remain free of obstruction as a part of the preventative maintenance program. To ensure compliance, the maintenance person will monitor and document results during weekly rounds for six months and ongoing. Any obstructions will be removed immediately and staff in the vicinity inserviced on the spot. Results will be reviewed at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 95% is not achieved, action plans will be revised.	

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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 record review and interview, the facility failed to ensure 31 of 31 battery backup emergency lights were tested annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. 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, as well as staff and visitors in the facility. Findings include: Based on record review on 07/09/19 between 11:40 a.m. and 5:10 p.m. with the Maintenance Supervisor present, there was documentation to show a 30 second monthly test of the 31 battery operated emergency light sets during the past twelve months, however, there was no documentation to show the 31 battery operated emergency light sets were tested annually for 90 minutes during the past twelve months. Based on	K 0291	K291 The maintenance person will replace the batteries and test the backup lights located in the corridor outside room 106, the corridor outside room 214, and outside the second floor med room. The maintenance person will check all battery operated back up lights for function and document results. The maintenance staff was inserviced on 8-1-19 regarding the monthly and annual testing of battery operated backup lights. Functional testing of battery operated back up lights will be conducted by the maintenance person monthly (test duration 30 seconds) and the results documented and available for inspection. Annually, the functional test will be performed for a duration of 90 minutes with distinguishing documentation of the prolonged test duration per the preventative maintenance program. Batteries used in back up lights will be approved for their intended use and shall comply with NFPA	08/03/2019

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	an interview at the time of record review, the Maintenance Supervisor said there was no other documentation available to show the 31 battery operated emergency light sets were tested annually for 90 minutes during the past twelve months. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 3 of 31 battery powered emergency light sets 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 at least 50 residents, as well as staff and visitors in the facility. Findings include: Based on observations on 07/09/19 between 11:40 a.m. and 5:10 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. The battery backup light set located in the corridor outside room 106 did not illuminate when tested several times b. The battery backup light set located in the corridor outside room 214 did not illuminate when tested several times c. The battery backup light set located in the		70 NEC. The maintenance person will monitor by providing test results documented on the QAPI audit form for six months at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 95% is not achieved, action plans will be revised to ensure compliance.	

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	corridor outside the second floor Med Room did not illuminate when tested several times. Based on interview at the time of each observation, the Maintenance Supervisor said he was unaware the battery backup light sets were not working and further said they all tested ok during the most recent monthly test dates of 06/13/19 through 06/20/19 . 3.1-19(b)			
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 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)			

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	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 2 of over 10 hazardous area doors, such as medical records storage rooms, were provided with proper doors with self closing devices. This deficient practice could affect at least 50 residents, as well as staff and visitors while using the Ball Room. Findings include: Based on observations on 07/09/19 between 11:40 a.m. and 5:10 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. The main medical records storage room next to the second floor Ball Room was over 50 square feet in size and filled with over 100 cardboard boxes and plastic totes full of paper medical records. The door to this room was a full length window glass pane door that was not provided with a self closing device. b. The secondary medical records storage room next to the second floor Ball Room was over 50 square feet in size and filled with over 100 cardboard boxes and plastic totes full of paper medical records. The door to this room was not provided with a self closing device. c. Due to a one foot by two foot open metal vent in the wall between the storage room and the Ball Room, the areas were not separated from other spaces by a smoke resisting partition. Based on interview at the time of each observation, the Maintenance Supervisor agreed these two storage room doors were not provided	K 0321	K321 The boxes and plastic totes stored in two rooms next to the second floor ballroom will be removed to an area with a smoke resistant and self-closing door. The soiled linen and trash carts were removed from the shower room next to room 122. All areas of the facility will be inspected to ensure there are no rooms being used for an unintended purpose, i.e. creating an unprotected hazardous area. The maintenance staff was inserviced on 8-1-19 regarding the Requirements for Hazardous Areas. Maintenance will inspect the facility monthly to ensure designated hazardous areas meet the Requirements i.e. are protected with resistant barriers/partitions and self-closing doors; and that non-designated rooms are not being be used for hazardous storage. All staff will be inserviced on the Requirements for Hazardous Areas. To ensure compliance, the maintenance person will monitor and document weekly rounds for	08/03/2019

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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
	with self closing devices and acknowledged the open vent in the wall, furthermore, the Maintenance Supervisor said these two medical records storage rooms were not meant to be used as storage rooms. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 4 shower room doors, a hazardous area room door due to the storage of soiled linen carts, was provided with a properly operating self closing device. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observation on 07/09/19 at 3:22 p.m. during a tour of the facility with the Maintenance Supervisor, the shower room next to 122 contained four soiled linen and trash carts of 32 gallon capacity each. The door to the corridor did have a self-closing device provided, however, it did not close and latch when tested several times. Based on interview at the time of observation, the Maintenance Supervisor agreed the door did not self close and latch when tested. 3.1-19(b)		two months and monthly for four months. Items will be removed immediately and staff in the vicinity inserviced on the spot for areas being used improperly for storage. Results will be reviewed at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 95% is not achieved, action plans will be revised.	
K 0345 SS=C 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,			

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	155616	A. BUILDING 01 B. WING	07/09/2019

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	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 maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. 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. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 07/09/19 between 11:40 a.m. and 5:10 p.m. with the Maintenance Supervisor present, no documentation could be provided regarding a visual semi-annual fire alarm system inspection. Based on interview at the time of record review, the Maintenance Supervisor said that visual inspections of the fire-alarm system's devices were not performed on a semi annual basis. 3.1-19(b)	K 0345	K345 The fire alarm system will be visually inspected by a certified fire alarm inspector and written verification of the inspection will be readily available. The deficient practice affects all residents and will be remedied by the corrective action taken. The maintenance staff was inserviced on 8-1-19 regarding the Requirements for semi-annual inspection of the fire alarm system by an approved vendor. A schedule for inspections by outside vendors has been established in the preventative maintenance calendar program (TELS) and will be monitored by the maintenance person and administrator. To ensure compliance, the administrator and maintenance person will meet monthly for six months and ongoing to anticipate regularly scheduled fire alarm system maintenance and inspections. Monitoring results will be reviewed at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 95% is not achieved,	08/03/2019

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			action plans will be revised.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 2 of over 500 sprinkler heads in the the facility were free of corrosion or paint. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at 5.2.1.1.1 requires sprinklers to be free of paint and corrosion. 5.2.1.1.2 requires any sprinkler that shows signs of paint or corrosion shall be replaced. This deficient practice could affect kitchen staff and residents, staff, and visitors in resident room 53. Findings include: Based on observations on 07/09/19 between 11:40 a.m. and 5:10 p.m. during a tour of the facility with the Maintenance Supervisor, the following was	K 0353	K353 (1) The sprinkler head located over the dishwasher in the kitchen and the sprinkler head over the bathroom door in room 53 will be replaced. (2) the 12" x 3" opening in the dishwashing room ceiling will be repaired; and, the ceiling tiles identified as missing will be replaced in the second floor elevator lobby, the two rooms off the ballroom being used for storage, and in the center dining room. (3) The wet sprinkler system gauge inspection, sprinkler system control valve inspection	08/03/2019

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	noted: a. One sprinkler head located over the dishwasher in the kitchen was covered with green corrosion b. One sidewall sprinkler head located over the bathroom door in room 53 was covered with paint Based on interview at the time of each observation, the Maintenance Supervisor agreed the two sprinkler heads were covered with green corrosion and paint and should be replaced. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure holes in ceiling drywall and ceiling tiles in 3 of 10 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect at least 50 residents, as well as staff and visitors. Findings include: Based on observations on 07/09/19 between 11:40 a.m. and 5:10 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. There was a 12 inch by 3 inch opening in the drywall ceiling in the kitchen dishwashing room b. There were four ceiling tiles missing above the elevator on the second floor elevator lobby next to the Ball Room c. There were twenty ceiling tiles missing in the Medical Records main storage room next to the Ball Room d. There were at least ten ceiling tiles missing in the Medical Records secondary storage room next to the Ball Room e. There were two ceiling tiles missing in the center dining room Based on interview at the time of observations,		and the dry system gauge inspection will be conducted and documentation of results available for review. In addition to the sprinkler gauge and valve inspections, all sprinkler heads will be inspected to ensure they are free of corrosion or paint; and, drywall and ceiling tiles are maintained to allow the sprinkler heads to function at full capacity as the deficient practice potentially affects all residents. The maintenance staff was inserviced on 8-1-19 regarding sprinkler system inspections. Results of the weekly inspection of the dry system gauges; monthly inspections of the wet system, and monthly visual inspections of the sprinkler heads and surrounding drywall and ceiling tiles will be documented on the QAPI audit form. The maintenance person will provide gauge and valve inspection and sprinkler pipe/head inspection results for six months at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 95% is not achieved, action plans will be revised to ensure compliance.	

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	the Maintenance Supervisor agreed there was a hole in the dishwashing room of the kitchen and missing ceiling tiles in other areas of the facility. The Maintenance Supervisor further said the missing ceiling tiles on the second floor were mainly due to a leaking roof and the hole in the dishwashing room was due to a leaky pipe. 3.1-19(b) 3. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler systems and 1 of 1 wet system during 52 of the past 52 weeks. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.2.4.1 states gauges on wet sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 07/09/19 between 11:40			

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	a.m. and 5:10 p.m. with the Maintenance Supervisor present, there was documentation available quarterly sprinkler inspections were performed on 08/29/18, 11/28/18, 03/07/19 and 06/12/19. Weekly dry sprinkler system gauge inspection documentation for 48 weeks of the most recent 52 week period was not available for review for the dry sprinkler system, furthermore, monthly wet sprinkler system gauge inspection documentation for 8 months of the most recent 12 month period for the wet sprinkler system was not available for review. In addition, monthly inspection documentation for the sprinkler system control valves for 8 months of the most recent 12 month period was also not available for review. Based on interview at the time of record review, this was acknowledged by the Maintenance Supervisor who said sprinkler system gauge and control valve inspection documentation for the past 12 month period was not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility between 11:40 a.m. to 5:10 p.m. the facility had 5 gauges at the sprinkler riser. 3.1-19(b)			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not			

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	require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 2 single fire/smoke barrier doors would close to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observation on 07/09/19 between 11:40 a.m. and 5:10 p.m. during a tour of the facility with the Maintenance Supervisor, the single fire/smoke barrier door between the AL Dining Room and the employee clock room failed to automatically close and latch when tested several times. There was a two inch gap between the entire length of the latching side of the door and its frame when closed fully. Based on interview at the time of observation, the Maintenance Supervisor agreed the door did not automatically close and latch when tested several times. Furthermore, he said this door was on his list of doors to be replaced. 3.1-19(b)	K 0374	K374 The smoke barrier door between the AL dining room and employee time clock area will be repaired to close automatically and latch. All smoke barrier doors will be inspected to ensure they close automatically and latch. The maintenance staff were inserviced on the operation and inspection of smoke barrier doors. Smoke barrier doors will be inspected monthly and integrated into the monthly preventative maintenance program. To ensure compliance, maintenance will monitor smoke barrier doors weekly for two months and bi-weekly for four months with results documented on a QAPI audit form. Repairs and adjustment will be made immediately if needed. Results will be reviewed at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 95% is not achieved, action plans will be revised.	08/03/2019
K 0511 SS=D	NFPA 101 Utilities - Gas and Electric			

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Bldg. 01	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 over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel	K 0511	K511 The electric receptacle near the sink in the employee breakroom will be provided with GFCI protection. Electrical receptacles near sinks throughout the facility were observed to determine if GFCI protection was provided and corrections made as needed. The maintenance staff was inserviced on the application of GFCI protection against electric shock. The maintenance person will inspect electrical receptacles to see if they are of the appropriate type per NFPA Standards quarterly. Results will be recorded on the QAPI inspection form. To ensure compliance, the maintenance person will monitor by checking electrical receptacles required to have GFCI protection monthly for six months and document results. Results will be reviewed at the monthly QAPI meeting overseen by the administrator and reported to	08/03/2019

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	are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect one staff person in the Employee Breakroom. Findings include: Based on observation on 07/09/19 between 11:40 a.m. and 5:10 p.m. during a tour of the facility with the Maintenance Supervisor, the Employee Breakroom had one electric receptacle on the wall		corporate compliance. If the threshold of 95% is not achieved, action plans will be revised.	

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	within two feet of the sink that was not provided with GFCI protection. This was confirmed when tested with a GFCI testing device. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 07/09/19 between 11:40 a.m. and 5:10 p.m. with the Maintenance Supervisor present, the facility lacked fire drill documentation for the third shift (night) of the first quarter (January, February, and March), and second quarter (April, May, and June) of 2019. Based on interview at the time of record review, the Maintenance Supervisor said there was no other documentation available to	K 0712	K712 Fire drills on each of three shifts at varied times were conducted and the date and time of drill were recorded on the fire drill record and are available for review. The deficient practice affects all residents. The maintenance staff was inserviced on 8-1-19 regarding fire drill policies and procedure and is responsible for planning and conducting fire drills at unexpected times under varying conditions, at least quarterly on	08/03/2019

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	show fire drills were performed during the third shift of the first and second quarters of 2019. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 07/09/19 between 11:40 a.m. and 5:10 p.m. with the Maintenance Supervisor present, nine of nine, second shift fire drills were performed between 2:00 p.m. and 3:37 p.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the times of the second shift fire drills and agreed they were not varied enough in time. 3.1-19(b)		each shift. The fire drill record will include the date and time the drill was conducted and will be available for review. A fire drill calendar of anticipated drills has been established. To ensure compliance, the maintenance person will provide fire drill records and results for six months at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 95% is not achieved, action plans will be revised.	
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where			

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	smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 areas where cigarettes were smoked by staff. This deficient practice could affect at least 2 staff while at the employee only outside smoking area. Findings include: Based on observation on 07/09/19 at 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, there where at least 25 cigarette butts in the trash receptacle mixed with paper and other trash. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)	K 0741	K741 A designated employee smoking area is established with ashtray/smoking tower receptacles of noncombustible material and safe design provided. A metal container with self-closing cover into which ashtrays can be emptied is readily available in the area. A metal trash can was inadvertently left in the area in which extinguished cigarette butts were comingled with regular trash. The metal trash can was removed from the area and signage prominently displayed with instructions for the disposal of cigarette butts. There is no other employee designated smoking area. The maintenance staff were	08/03/2019

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NEW ALBANY NURSING AND REHABILITATION CENTER	201 E ELM ST NEW ALBANY, IN 47150

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			inserviced on maintaining the designated smoking area and have been assigned to empty the ashtrays daily. An audit form including compliance with the procedure for disposal of cigarette butts was implemented. All staff will be inserviced on proper disposal of cigarette butts in the designated smoking area. The maintenance person will audit daily for one month, weekly for two months, and monthly for three months for a total of six months. If threshold of 95% compliance is not achieved an action plan will be developed. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less			

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	than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure 5 of 5 soiled linen receptacles in the second floor 200 hall and the first floor center corridor were maintained in accordance with 19.7.5.7. Section 19.7.5.7(2) states that a capacity of 32 gallons shall not be exceeded within any 64 square foot area. This deficient practice could affect at least 25 residents, as well as staff and visitors in the facility. Findings include: Based on observations on 07/09/19 between 11:40 a.m. and 5:10 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. Two soiled linen carts in excess of 32 gallons were being stored in the first floor center corridor near resident room 16 b. Two soiled linen connected carts in excess of 32 gallons each, plus a large rubber barrel in excess of 32 gallons were being stored in the second floor corridor near resident rooms 227 and 229. Based on interview at the time of each observation, the Maintenance Supervisor agreed the carts all exceeded 32 gallons and should be stored in a hazardous area. 3.1-19(b)	K 0754	K754 The soiled linen carts and barrel in excess of 32 gallons were removed from the first floor center corridor and second floor corridor to the soiled utility rooms on each floor. All corridors were inspected for carts and barrels in excess of 32 gallons which may have been left in a corridor unattended were returned to the respective soiled utility rooms. Maintenance staff was inserviced on storage of soiled linen carts and barrels in excess of 32 gallons. All staff will be inserviced on proper storage placement of the soiled carts and barrels. To monitor compliance, housekeeping staff have been designated to make rounds daily for six months to ensure there are no unattended soiled linen containers and all containers at 32 gallon capacity or larger are properly stored in the soiled utility room. Trends will be reported to the housekeeping supervisor who will report findings monthly to the QAPI committee overseen by the administrator and reviewed by	08/03/2019

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			corporate risk management. If threshold of 95% compliance is not achieved an action plan will be developed.	
K 0761 SS=C Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 3 of 3 stairway fire door assemblies and 1 of 1 oxygen room fire door assembly was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads	K 0761	K761 The three stairway doors and oxygen transfill room door fire assemblies will be inspected and findings documented. There are no other fire door assemblies in the building. The maintenance staff were inserviced on the annual fire door assembly inspection requirements. The fire door assemblies have been added to the preventative maintenance calendar (TELS). Results of the fire door assembly inspection results will be documented on the Fire Door Assembly Inspection form and available for review. To ensure compliance, the administrator and maintenance person will meet monthly for six months and ongoing to review (TELS) and anticipate regularly scheduled inspections. Monitoring results will be reviewed at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 95% is not	08/03/2019

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	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 prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 07/09/19 between 11:40 a.m. and 5:10 p.m. with the Maintenance Supervisor present, the facility was unable to provide documentation for the annual inspection of fire door assemblies, including three stairway fire door assemblies and one oxygen transfilling room fire door assembly. Based on interview at the time of record review, the Maintenance Supervisor said the facility has not conducted an annual inspection of fire door assemblies as of yet. Based on observations during a tour of the facility with the Maintenance Supervisor between		achieved action plans will be revised.	

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	11:40 a.m. and 5:10 p.m., there were three stairway door assemblies and one oxygen transfilling room fire door assembly noted in the facility. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure all nonhospital-grade electrical receptacles in 82 of 82 resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles	K 0914	K914 The electrical receptacles in the 82 of 82 resident room locations will be inspected visually for physical integrity and tested for correct polarity and retention force	08/03/2019

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	not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review on 07/09/19 between 11:40 a.m. and 5:10 p.m. with the Maintenance Supervisor present, there was no record of an annual test for each resident room electrical receptacle that was not a hospital-grade receptacle. Based on interview at the time of record review, the Maintenance Supervisor said all of the electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. He further said there was no record or documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met. Based on observations between 11:40 a.m. and 5:10 p.m. during a tour of the facility with the Maintenance Supervisor, there were at least four to six electrical receptacles in each of the resident rooms. 3.1-19(b)		and results documented. The deficient practice affects all resident room locations. An electrical receptacle inspection and testing log was obtained, and the maintenance person was inserviced 8-1-19 on the procedure for inspecting and testing non-hospital grade receptacles at intervals not to exceed twelve months. The electrical receptacle inspection and testing were added to the preventative maintenance schedule. The maintenance person will check the electrical receptacles for physical integrity and note any receptacle replacements/upgrades and add them to the schedule, and document findings on the inspection testing log, weekly for one month and monthly for six months. The audit logs will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator	K 0918	K918 The approved generator	08/03/2019

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	was in proper operating condition. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on observation on 07/09/19 between 11:40 a.m. and 5:10 p.m. during a tour of the facility with the Maintenance Supervisor, the generator annunciator panel located in the 100 hall dining room across from the Nurses' Station had the "High Water Temperature" light (red) illuminated. The Maintenance Supervisor said this trouble light has been on the the past couple of months. Furthermore, when checking the annunciator panel located on the generator the "High Water Temperature" light (red) was also illuminated. This was acknowledged by the Maintenance Supervisor at the time of observation, who further said the generator does not start automatically weekly on its own with the built-in timer. He said he has to manually start the generator during its weekly test. He said this has been going on for about two months. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 4 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having		maintenance and repair vendor will trouble-shoot the “high water temperature” warnings on the annunciator panel at the nurses’ station and at the generator; check the auto-start function; and, make repairs or adjustments as needed. The generator will be inspected, tested and exercised under load for thirty minutes and results documented. Documentation will include a 5-minute cool down period after a load test and calculation of the percentage of load during the exercise. There is only one generator on the property affecting all residents. The maintenance person was inserviced on 8-1-19 regarding weekly inspection and testing, exercising the generator under load monthly for thirty minutes, and data the required to be recorded. The generator will be tested and inspected weekly and exercised monthly under load for thirty minutes by the maintenance person who will maintain documentation of the inspections and testing results. Generator maintenance, testing and inspection is part of the preventative maintenance program. The inspection/testing form will serve as the audit tool and inspection/testing results will be documented.	

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	jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 07/09/19 between 11:40 a.m. and 5:10 p.m. with the Maintenance Supervisor present, there was no monthly generator load test documentation available for October of 2018, and January, May, and June of 2019. Based on interview at the time of record review, the Maintenance Supervisor confirmed there was no emergency generator load test documentation available for the previously mentioned months in 2018 and 2019. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 41 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.		The administrator will monitor the weekly/monthly inspection and testing; and maintenance by outside contractor for six months and ongoing. The results will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	Findings include: Based on review of the weekly generator inspection reports on 07/09/19 between 11:40 a.m. and 5:10 p.m. with the Maintenance Supervisor present, there was no weekly generator testing documentation available during the past 12 months except for the weeks between 01/12/19 and 03/11/19. Based on interview at the time of record review, the Maintenance Supervisor said he was unable to find weekly generator testing documentation for the past 12 months except for the weeks between 01/12/19 and 03/11/19. 3.1-19(b) 4. Based on record review and interview, the facility failed to ensure documentation for 1 of 1 emergency generator included a 5 minute cool down period after a load test for 5 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 6.4.2.1.5.9 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 07/09/19 between 11:40 a.m. and 5:10 p.m. with the Maintenance Supervisor present, the monthly load test for the			

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	emergency generator during November and December of 2018, and February, March, and April of 2019 had a cool down time following its load tests listed as only 2 minutes. Based on interview at the time of record review, the Maintenance Supervisor said the generator does have a cool down time after each monthly load test, but acknowledged the previously mentioned months did not meet the required 5 minute minimum cool down time. 3.1-19(b) 5. Based on record review and interview on 07/09/19 between 11:40 a.m. and 5:10 p.m. with the Maintenance Supervisor present, the facility failed to properly document the percentage of load during each monthly exercise for 1 of 1 emergency generator to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a			

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	total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on review of generator's monthly load test log on 07/09/19 between 11:40 a.m. and 5:10 p.m. with the Maintenance Supervisor present, the monthly load test log always had the percentage of load at 55% or 100%. When asked how the percentage of load was calculated during each monthly load test, the Maintenance Supervisor said he did not actually calculate a percentage of load and that the 55% or 100% used was just a standard answer for the facility's on line electronic generator program. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are			

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NEW ALBANY NURSING AND REHABILITATION CENTER	201 E ELM ST NEW ALBANY, IN 47150

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	used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure extension cords and power strips were not used as a substitute for fixed wiring in 2 of 82 resident rooms and one Activity Room. LSC 19.5.1.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observations on 07/09/19 between 11:40 a.m. and 5:10 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. There was a chest freezer plugged into a power strip in the Activity Room b. Resident room 102 had a TV plugged into a power strip c. Resident room 101 had a phone charger plugged into an extension cord that was attached to the bed and several items plugged into a power strip The UL rating on the power strips mentioned in the resident rooms did not meet the power strip requirements of UL 1363 for resident care rooms. This was acknowledged by the Maintenance	K 0920	F920 The power strips in the activity room and resident room 102 and the extension cord in rm 101 were removed. All resident rooms and common areas were checked for power strips and extension cords Power strips in resident rooms that did not meet the requirements of UL 1363 were removed Maintenance was inserviced on 8-1-19 on the use of unauthorized power strips in common areas and resident care rooms. All staff were inserviced on the use of power strips and extension cords in common areas and resident rooms. Housekeeping will inspect resident rooms and common areas weekly for power strips and extension cords and bring them to the attention of maintenance and/or administrator. A policy on use of extension cords and power strips will be provided in the resident admission handbook and admission packet. The housekeeping supervisor will	08/03/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 01 B. WING	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Supervisor at the time of each observation. 3.1-19(b)		track the results of weekly housekeeping inspections and provide results for review at the monthly QAPI committee meeting. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	