STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155539	A. BUILDING -- B. WING	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BERTHA D GARTEN KETCHAM MEMORIAL CENTER	601 E RACE ST ODON, IN 47562

(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: 12/13/23 and 12/14/23 Facility Number: 000300 Provider Number: 155539 AIM Number: 100287340 At this Emergency Preparedness survey, Bertha D. Garten Ketcham Memorial Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 72 certified beds and had a census of 48 at the time of this visit. Quality Review completed on 12/21/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective January 19, 2024 to the state findings of the Life Safety Code Recertification State Licensure Survey and Emergency Preparedness Survey conducted on December 14, 2023.	
E 0015 SS=F Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy Wittmer	HFA	01/24/2024

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients 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 the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health			

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	and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. 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) 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 Preparedness Plan on 12/13/23 between 2:20 p.m. and 3:45 p.m. with the Assistant Administrator present, the plan provided did not address the loss of sewage and waste disposal to protect residents health and safety in an emergency. Based on interview at the time of records review, the Assistant Administrator confirmed the plan provided did not address the loss of sewage and waste disposal to protect residents health and safety in an emergency. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23.	E 0015	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective January 7, 2024 to the state findings of the Life Safety Code Recertification State Licensure Survey and Emergency Preparedness Survey conducted on December 14, 2023. E 015 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, this deficient practice has the potential to affect all residents, staff and visitors. The facility has now developed and implemented a plan with policies and procedures to address the loss of sewage and waste disposal in the event of an emergency to protect the health and safety of the residents, staff and visitors.	01/05/2024

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			The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now developed and implemented a plan with policies and procedures to address the loss of sewage and waste disposal in the event of an emergency to protect the health and safety of the residents, staff and visitors. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's new emergency preparedness policies and procedures related to the loss of sewage and waste disposal. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the facility administration will review twice a year the policies and procedures related to the facility's emergency preparedness plan, including the policy and procedure related to the loss of sewage and waste disposal to ensure all policies continue to be effective and pertinent to the facility's needs. The policy will be amended when and if warranted.	

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E 0024 SS=F Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and			

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	procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency/Disaster Preparedness Plan on 12/13/23 between 2:20 p.m. and 3:45 p.m. with the Assistant Administrator present, the facility's plan did not address the use of volunteers in an emergency. Based on interview at the time of review, the Assistant Administrator confirmed the plan provided did not address the use of volunteers in an emergency. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23.	E 0024	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, this deficient practice has the potential to affect all residents, staff and visitors. The facility has now updated the facility's emergency preparedness plan to address the use of volunteers in the event of an emergency. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now updated the facility's emergency preparedness plan to address the use of volunteers in the event of an emergency. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all management staff on the facility's emergency preparedness plan which addresses the use of volunteers in an emergency as to the roles that	01/04/2024

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			the volunteers will fulfill in the event of an emergency. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the facility administration will review annually the policies and procedures related to the facility's emergency preparedness plan, including the policy and procedure related to the use of volunteers during an emergency to ensure the policies and procedures remain effective and pertinent to the facility's needs. The policy will be amended when and if warranted.	
E 0034 SS=F Bldg. --	403.748(c)(7), 416.54(c)(7), 418.113(c)(7), 441.184(c)(7), 482.15(c)(7), 483.475(c)(7), 483.73(c)(7), 484.102(c)(6), 485.625(c)(7), 485.68(c)(5), 485.727(c)(5), 485.920(c)(7), 491.12(c)(5), 494.62(c)(7) Information on Occupancy/Needs §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:			

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	(7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency/Disaster Preparedness Plan on 12/13/23 between 2:20 p.m. and 3:45 p.m. with the Assistant Administrator present, a communication plan that included a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7) was not available for review. Based on interview	E 0034	E 034 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, this deficient practice has the potential to affect all residents, staff and visitors. The facility has now developed an emergency preparedness communication plan which includes a manner of providing information about the LTC facility's occupancy, needs and its ability to provide assistance to the authority having jurisdiction or the Incident Command Center, or designee in accordance with the regulations in the event of an emergency. *The corrective action taken for the*	01/04/2024

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	at the time of record review then again at the exit conference, the Assistant Administrator confirmed that the communication plan did not include the aforementioned occupancy, needs, and ability to provide assistance to the AHJ, IC, or designee. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23.		*other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now developed an emergency preparedness communication plan which includes a manner of providing information about the LTC facility's occupancy, needs and its ability to provide assistance to the authority having jurisdiction or the Incident Command Center, or designee in accordance with the regulations in the event of an emergency. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's emergency preparedness communication plan. The staff has been instructed on their roles in the manner of which they are to provide information about the LTC facility's occupancy, needs and its ability to provide assistance to the authority having jurisdiction or the Incident Command Center, or designee in accordance with the regulations in the event of an emergency. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the facility administration will review annually the policies and procedures related to the facility's	

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			emergency preparedness communication plan to ensure that it remains effective and pertinent to the facility's needs. The policy will be amended when and if warranted.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies			

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	and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of			

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	emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training.			

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	(iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.			

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	155539	A. BUILDING -- B. WING	12/14/2023

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	(ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.			
	Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include:	E 0037	E 037 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, this deficient practice has the potential to affect all residents, staff and visitors. The facility has now conducted a mandatory in-service for all staff on the facility's emergency preparedness program. The staff has been re-educated on their respective responsibilities as outlined in the emergency preparedness program. The facility will continue to train all new	01/04/2024

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	Based on review of the Emergency/Disaster Preparedness Plan on 12/13/23 between 2:20 p.m. and 3:45 p.m. with the Assistant Administrator present, no documentation of annual emergency preparedness training and no documentation to show staff could demonstrate knowledge of the emergency preparedness plan was available for review. Based on an interview at the time of record review, the Assistant Administrator confirmed there was no documentation of annual emergency preparedness plan training and no documentation to show staff could demonstrate knowledge of the emergency preparedness plan was available for review. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23.		employees on the facility's emergency preparedness program upon hire and will also provide emergency preparedness training at least annually. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now conducted a mandatory in-service for all staff on the facility's emergency preparedness program. The staff has been re-educated on their respective responsibilities as outlined in the emergency preparedness program. The facility will continue to train all new employees on the facility's emergency preparedness program upon hire and will also provide emergency preparedness training at least annually. *The measures that have been put into place to ensure that the deficient practice does not recur is that* the facility has developed and implemented an annual in-service schedule which includes at least annual training on the facility's emergency preparedness program. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* all department directors will now be responsible for ensuring that there is documentation in their	

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			employee's records to support that each of their employees has successfully completed annual training on the facility's emergency preparedness program.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based			

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	functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the			

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	onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or			

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	(B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that			

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	is led by a facilitator and includes a group discussion, 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group			

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	discussion, 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed			

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	messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 ICF/IID's response to and			

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	maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 HHA's response to and maintain documentation of all drills, tabletop			

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	exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is 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. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise			

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	the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. 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 its next required full-scale in a community-based or individual, facility-based full-scale functional 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 an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, 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 in the facility. Findings include:	E 0039	E 039 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, this deficient practice has the potential to affect all residents, staff and visitors. The facility has now conducted an additional exercise of the facility's emergency plan. The facility has documentation of the completion of this exercise. The facility will continue to conduct exercises of its emergency plan at least twice a year. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now conducted an additional exercise of the facility's emergency plan. The facility has documentation of the completion of this exercise. The facility will continue to conduct exercises of its emergency plan at least twice a year. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the facility administration on the regulation related to the required testing of	01/04/2024

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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
	Based on review of the Emergency/Disaster Preparedness Plan on 12/13/23 between 2:20 p.m. and 3:45 p.m. with the Assistant Administrator present, the facility was able to provide documentation of a table top exercise dated 03/16/23 for the Rose House, and documentation of an actual event for the main building dated 12/06/23, however, the facility was unable to provide documentation of a second exercise performed during the past 12 month period for the main building and Rose House. This was confirmed by the Assistant Administrator during record review. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23.		the facility emergency plan. Tentative plans were developed for the required testing of the facility's emergency plan. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Quality Assurance team will review the documentation of the testing of the facility's emergency plan testing at the Quality Assurance meetings at least quarterly to ensure that there is timely documentation to support the testing of the emergency plan in accordance with the regulation.	
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: 12/13/23 and 12/14/23 Facility Number: 000300 Provider Number: 155539 AIM Number: 100287340 At this Life Safety Code survey, Bertha D. Garten Ketcham Memorial 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,	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective January 19, 2024 to the state findings of the Life Safety Code Recertification State Licensure Survey and Emergency Preparedness Survey conducted on December 14, 2023.	

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	155539	A. BUILDING 01 B. WING	12/14/2023

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	Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. A portion of the facility was determined to be two story due to an occupied space above the main entrance, dining room and west nurses' station areas, this portion of the facility was determined to by of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The main building of the facility has a capacity of 62 and had a census of 38 at the time of this survey. The Rose House has a capacity of 10 and had a census of 10 at the time of this survey. Combined, the facility has a capacity of 72 and had a census of 48 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except, one detached garage used for facility storage, and one detached office building used by employees only. Quality Review completed on 12/21/23			
K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number			

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	of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on record review, observation and interview; the facility failed to ensure the construction type of the facility meets the requirements of a two story, fully sprinklered building, and be of at least Type V (111). This deficient practice could affect all residents, staff, and visitors while in the Dining Room of the Main Building. Findings include:	K 0161	K 161 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents staff and visitors in the main dining room of the facility have the potential to be affected by this	01/06/2024

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	Based on record review on 12/13/23 between 9:00 a.m. and 3:45 p.m. with the Maintenance Supervisor present, the construction type of the facility for the Main Building was determined to be Type V (000). This was confirmed by the Maintenance Supervisor at the time of record review. Based on observations between 4:50 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Supervisor, the attic space over a portion of the facility; including the front entrance area, main dining room, and west nurses's station, was an occupied space/floor which included the storage of many file cabinets, cardboard boxes, totes, plastic, paper, mattresses, PPE, and much general storage. Based on interview, the Maintenance Supervisor said staff uses this attic space/floor on a regular basis. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)		deficient practice. The identified storage items, such as file cabinets, cardboard boxes, totes, plastic, paper, mattresses, PPE and other general storage items stored in the attic have now been removed from the attic. The identified attic area will no longer be utilized for storage of any type of materials. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors in the main dining area have the potential to be affected by this deficient practice. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the regulation related to building construction. The maintenance supervisor has been instructed that the attic is no longer to be utilized for storage of any type of materials. The maintenance supervisor was also instructed on their responsibility to check the attic area monthly to ensure no items have been taken to this area for storage as part of the facility's preventative maintenance program. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the administrator and/or assistant	

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			administrator will review the preventative maintenance program documentation monthly to ensure that monthly checks of the storage area have been completed and verified that no items/materials are being stored in the attic.	
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review and interview, the facility failed to ensure there was complete documentation for the testing of 1 of 1 battery backup light that was tested monthly for 30 seconds during the past 12 months. 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 12/13/23 between 9:00	K 0291	K 291 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. There is now documentation to support that all battery-operated backup lights have been tested for at least thirty seconds, including the battery backup light located at the generator. The facility will now consistently test all battery-operated backup lights monthly and document all required components of the testing including the 30 second testing period. *The corrective action taken for the*	01/04/2024

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	a.m. and 3:45 p.m. with the Maintenance Supervisor present, the facility did have a preventative maintenance (PM) report that the battery powered emergency light set at the generator was tested monthly, however, the monthly PM was not complete. The monthly test indicated the battery powered emergency light set was only tested for 15 seconds, furthermore, there were no monthly tests performed during March, September, and November of 2023. Based on an interview at the time of record review, the Maintenance Supervisor agreed the PM form for the battery powered emergency light set was not complete and confirmed there were three months where the light set was not tested. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)		*other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. There is now documentation to support that all battery-operated backup lights have been tested for at least thirty seconds, including the battery backup light located at the generator. The facility will now consistently test all battery-operated backup lights monthly and document all required components of the testing including the 30 second testing period. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on their responsibility to ensure that monthly testing of all battery-operated backup lights is being conducted and documented in accordance with the regulation. The documentation shall include the 30 second testing period. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the administrator and/or assistant administrator will now review monthly the preventative maintenance documentation on the testing of the battery-operated backup lights to ensure that all documentation has been	

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			completed accurately and in accordance with the regulations. Any concerns identified will be promptly reviewed with the maintenance supervisor so that immediate corrective action can be taken.	
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) e. Trash Collection Rooms (exceeding 64 gallons)			

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	f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as a storage room door, was provided with a self closing device. This deficient practice could affect up to 10 residents and staff while in the Physical Therapy Gym. Findings include: Based on observations on 12/13/23 between 4:50 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Supervisor, the Physical Therapy storage room was over 50 square feet in size, and contained at least 30 cardboard boxes, totes, paper, and plastic items, along with Physical Therapy storage. The door to this room was not provided with a self closing device. This was confirmed by the Maintenance Supervisor at the time of observation. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)	K 0321	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified all residents and staff in the physical therapy gym have the potential to be affected by this deficient practice. A self-closing device has now been placed on the physical therapy storage room door and is functioning properly. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents and staff in the physical therapy gym have the potential to be affected by this deficient practice. A self-closing device has now been placed on the physical therapy storage room door and is functioning properly. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the regulation related to the requirements of hazardous storage areas. The maintenance supervisor was instructed that it is their responsibility to ensure that the regulations are being followed to ensure the proper safety/security	01/12/2024

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			is maintained in the hazardous storage areas. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a housewide audit of all areas of the facility has been conducted to identify each hazardous storage room to ensure that these areas are being maintained in accordance with the regulation including self-closing devices on the doors. These doors will be monitored in accordance with the regulation as part of the facility's preventative maintenance program to ensure that the self-closing device is in place and functioning properly.	
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with			

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	conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the proper use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff plus all residents while in the adjacent main dining room. Findings include: Based on observations on 12/13/23 between 4:50 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Supervisor, the kitchen was provided with a UL 300 hood system. Based on interview with three kitchen staff, when asked what they would do if there was a fire underneath the hood. All three said they didn't really know. Kitchen staff #1 finally said she would go pull the pull station near the exit door from the dining room. No one said they would pull the range hood fire suppression system pull station. This was acknowledged by the Maintenance Supervisor at the time of observation and interview with the three kitchen staff. The	K 0324	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all kitchen staff and resident and visitors in the main dining room have the potential to be affected by this deficient practice. All dietary staff have now been instructed on the proper use of the UL300 hood fire suppression system in the kitchen. All new dietary staff will also be instructed on the proper use of the UL300 hood fire suppression system as part of their job specific orientation. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all kitchen staff, residents and visitors in the main dining room have the potential to be affected by this deficient practice. All dietary staff have now been instructed on the proper use of the UL300 hood fire suppression system in the kitchen. All new dietary staff will also be instructed on the proper use of the UL300 hood fire suppression system as part of	01/04/2024

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	Maintenance Supervisor said more training for kitchen staff would be a priority. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)		their job specific orientation. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all dietary staff on the proper use of the UL300 hood fire suppression system in the kitchen. In addition, instruction on the proper use of the UL300hood fire suppression system in the kitchen has now become a part of the dietary staff's job specific orientation. In addition, instruction on the proper use of the UL300 hood fire suppression system has now been added to the dietary staff's annual in-service schedule. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* all dietary staff's personnel files will be audited annually to ensure there is documentation to support that they have been instructed on the UL300 hood fire suppression system in the kitchen.	
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, National Fire Alarm and Signaling Code.			

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	Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Supervisor on 12/13/23 at 4:57 a.m., the date and time on the main fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the time to be 5:14 p.m. Furthermore, the date on the panel showed it to be 12/14/2023 and not the correct date of 12/13/2023. Based on interview at the time of observation, the Maintenance Supervisor indicated he was not aware of the discrepancy and would speak with the fire alarm inspection company to get the time and date set correctly. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)	K 0345	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors of the Rose House have the potential to be affected by this deficient practice. The facility has now conducted sensitivity testing on all smoke detectors and there is documentation on file for review by the authorities of this testing. The facility will continue to ensure that the smoke detectors have a sensitivity test completed at least every 24 months as required by the regulation. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors of the Rose House have the potential to be affected by this deficient practice. The facility has now conducted sensitivity testing on all smoke detectors and there is documentation on file for review by the authorities of this testing. The facility will continue to ensure that the smoke detectors have a sensitivity test completed at least every 24 months as required by the regulation. *The measures that have been put*	01/04/2024

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			into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for the maintenance supervisor on the regulation related to the sensitivity testing requirements of smoke detectors. The maintenance supervisor was instructed on their responsibility to ensure the smoke detector sensitivity testing is completed every 24 months and documentation of this testing retained on file for review by the authorities in accordance with the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the administrator and/or assistant administrator will now be reviewing the documentation on the sensitivity testing of the smoke detectors in the Rose House every 24 months to ensure that the documentation has been completed timely. Any concerns identified will be promptly discussed with the maintenance supervisor for immediate corrective action.	

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K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the sprinkler system piping was properly secured in 1 of 1 attic area. NFPA 13, 2010 Edition, Installation of Sprinkler Systems, Section 9.2.3.7 states Sprigs 4 feet or longer shall be restrained against lateral movement. This deficient practice could affect all residents, staff, and visitors in the Main Building. Findings include: Based on observations on 12/13/23 between 4:50 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Supervisor, there were at least 40 or more sprinkler pipe sprigs in the attic space that were not restrained against lateral movement. The	K 0351	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. All the identified sprinkler pipe sprigs in the attic space have now been secured/restrained against lateral movement in accordance with the regulation. *The corrective action taken for the other residents that have the*	01/04/2024

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	sprinkler pipe sprigs were at least 5 feet 3 inches and mostly located above the east, center, and west corridors. This was acknowledged by the Maintenance Supervisor at the time of observations. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)		*potential to be affected by the same deficient practice is that* all residents staff and visitors have the potential to be affected by this deficient practice. All sprinkler pipe sprigs in the attic space have now been secured/restrained against lateral movement in accordance with the regulation. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the regulation related to ensuring that the sprinkler system piping sprigs are properly secured/restrained against lateral movement. The maintenance supervisor was educated on their responsibility for ensuring that the facility's sprinkler system was properly maintained in accordance with the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* as part of the facility preventative maintenance program, annual inspection of the sprinkler system piping will be conducted to ensure that each sprinkler system piping sprig is secured/restrained against lateral movement. These inspections will be documented in the preventative maintenance log along with any needed repairs/maintenance that is required.	

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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 record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping system was inspected every five years in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 14.2.1 states an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. Alternative nondestructive examination methods shall be permitted. Non-metallic pipe shall not be	K 0353	*1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now had the automatic sprinkler piping system inspected and there is documentation on file for review by the authorities of this inspection. *2.) The corrective action taken for those residents found to have*	01/19/2024

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	required to be inspected internally. 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 affects all residents, staff and visitors in the Main Building. Findings include: Based on record review on 12/13/23 between 9:00 a.m. and 3:45 p.m. with the Maintenance Supervisor present, documentation of an internal inspection of the Main Building sprinkler system performed within the most recent five year period was not available for review. Documentation for the most recent internal pipe inspection performed was dated 09/04/18. Based on interview at the time of record review, the Maintenance Supervisor confirmed documentation of an internal inspection of the sprinkler system within the most recent five year period was not available for review. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the ceiling in 1 of 6 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect all residents, staff, and visitors while in the main dining room, which was adjacent to the west nurses' station. Findings include:		*been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents on the west unit, as well as west unit staff and visitors have the potential to be affected by this deficient practice. The ceiling in the west unit nurses station med room has now been repaired and a new escutcheon ring has been placed on the sprinkler head allowing the sprinkler head to function to its full capacity. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors on the east unit have the potential to be affected by the deficient practice. The sprinkler head covered with corrosion identified at the east back exit overhang has been replaced. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now had the automatic sprinkler piping system inspected and there is documentation on file for review by the authorities of this inspection. A housewide audit of all ceiling areas around sprinkler	

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	Based on observations on 12/13/23 between 4:50 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Supervisor, the sprinkler head in the west nurses' station med room was missing its escutcheon ring which left a half inch gap around the sprinkler head to the attic space. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the half inch gap around the west nurses' station med room sprinkler head that penetrated the ceiling and said he would correct the issue as soon as possible. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 6 smoke compartments covered with corrosion was replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect up to 20 resident, as well as staff and visitors in the east corridor. Findings include: Based on observations on 12/13/23 between 4:50		heads has been conducted to ensure that there are no holes or obstruction that would prevent the sprinkler head from functioning to their full capacity. No other compromised ceiling areas around the sprinkler heads were identified. A housewide audit of all sprinkler heads has been completed to ensure that they are free from corrosion. No other corroded sprinkler heads were identified. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the regulation regarding the maintenance and testing of the sprinkler system. The maintenance supervisor was educated on their responsibility for ensuring that all inspections, testing and maintenance of the sprinkler system in accordance with the regulation is their responsibility, as well as ensuring that the required supportive documentation of all inspections, testing and maintenance must be maintained by the supervisor for review by the authorities. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the administrator and/or assistant administrator will now review monthly the maintenance supervisor's supportive	

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	p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Supervisor, there was a sprinkler head under the east back exit overhang covered with corrosion. Based on interview at the time of observation, the Maintenance Supervisor agreed the sprinkler head under the east back exit overhang was covered with corrosion and should be replaced. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)		documentation on the inspections, testing and maintenance of the facility's sprinkler system to ensure compliance with the regulation. Any concerns identified by administration will be promptly addressed with and corrected by the maintenance supervisor.	
K 0511 SS=D 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 over 10 wet locations, was 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,	K 0511	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, nursing staff on the east nurses' station have the potential to be affected by this deficient practice. The identified electrical receptacle in the east nurses' station med room has now been replaced and provides ground fault circuit interrupter protection against shock. *The corrective action taken for the*	01/19/2024

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	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 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		*other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A housewide audit of all wet locations has been conducted to ensure that electrical receptacles in the wet locations have the appropriate ground fault circuit interrupter protection to prevent electric shock. No other electrical receptacles were identified. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the regulation related to wet location electric receptacles. The maintenance supervisor was educated on their responsibility for ensuring that wet location electric receptacles have the proper ground fault circuit interrupter protection against shock. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* as part of the on-going preventative maintenance program, the maintenance supervisor will monitor to ensure that all wet locations have the proper electric receptacles properly installed with protection against shock.	

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	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 mostly nursing staff. Findings include: Based on observations on 12/13/23 between 4:50 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Supervisor, there were three electric receptacles within three feet of the sink in the east nurses' station Med Room. The receptacle on the left was provided with a GFCI receptacle and the other two were piggy backed to the first. When tested with a GFCI testing device it indicated the receptacle was properly wired, however, the electrically circuit was not interrupted for any of the three receptacles. When tested with the test button on the first receptacle the electrically circuit was interrupted for all three receptacles. Based on interview at the time of observation, the Maintenance Supervisor agreed the GFCI receptacles in the east nurses's station Med Room were functioning properly and he would replace them as soon as possible. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)			
K 0711 SS=F	NFPA 101 Evacuation and Relocation Plan			

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Bldg. 01	Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of 38 of 38 residents in the Main Building to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled	K 0711	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey all residents, staff and visitors have the potential to be affected by this deficient practice. The facility fire safety plan has now been amended to include the location of the smoke barriers within the facility. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility fire safety plan has now been amended to include the location of the smoke barriers within the facility. *The measures that have been put into place to ensure that the*	01/05/2024

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	equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's "Fire Plan" on 12/13/23 between 9:00 a.m. and 3:45 p.m. with the Maintenance Supervisor and Assistant Administrator present, the plan did address evacuation of the smoke compartment, however, the plan did not identify where the smoke barriers were located in the facility. Based on interview at the time of record review, the Maintenance Supervisor and Assistant Administrator acknowledged and agreed that the Fire Plan did not identify where the smoke barriers were located in the facility. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)		*deficient practice does not recur is that* a mandatory in-service has been provided for administration and the maintenance supervisor on the regulation related to the requirements of a fire safety, evacuation and relocation plan. Administration and the maintenance supervisor were educated on their responsibility on ensuring that all components of the regulation are outlined in the facility's fire safety plan. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the facility's fire safety plan will be reviewed by the Quality Assurance committee at least bi- annually to ensure that all components of the regulation are outlined in the facility's fire safety plan. Modifications to the fire safety plan will be made when warranted or required by regulation.	
K 0761 SS=F Bldg. 01	Based on record review, observation, and interview; the facility failed to ensure a complete annual inspection and testing of 1 of 1 stairway fire door assembly, and 1 of 1 oxygen transfilling room door assembly was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in	K 0761	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey all residents,	01/04/2024

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	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 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.		staff and visitors have the potential to be affected by this deficient practice. The form utilized to document the annual inspection and testing of smoke barrier and fire rated doors has been amended and now contains documentation for the inspection of the door assemblies. All smoke barrier and fire rated doors have now been inspected/tested and there is documentation to support these inspections/testing including documentation of the inspection of the door assemblies. These inspections also included the stairway fire door and the door to the oxygen transferring room. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. All smoke barrier and fire rated doors have now been inspected/tested and there is documentation to support these inspections/testing including documentation of the inspection of the door assemblies. These inspections also included the stairway fire door and the door to the oxygen transferring room. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the regulation	

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	(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. Findings include: Based on record review on 12/13/23 between 9:00 a.m. and 3:45 p.m. with the Maintenance Supervisor present, the facility did provide documentation of a form used for the annual inspection of all of the facility's smoke barrier and fire rated door assemblies, however, the documentation provided was not filled out to prove the fire door assemblies were inspected. Based on interview at the time of record review, the Maintenance Supervisor said the documentation provided was the only inspection and testing documentation available for the annual inspection/testing of the facility's fire door assemblies. Based on observations during a tour of the facility with the Maintenance Supervisor between 4:50 p.m. and 6:30 p.m., there was 1 stairway fire door assembly and 1 oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference. 3.1-19(b)		related to the maintenance, inspection and testing of smoke barrier and fire rated doors. The maintenance supervisor was educated on the required documentation that must be included with each inspection in accordance with the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the administrator and/or assistant administrator will now be reviewing annually the documentation on the maintenance, inspection and testing of smoke barrier and fire rated doors. Administration will ensure that the documentation includes the inspection of the door assemblies in accordance with the regulation.	

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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 complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care	K 0914	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents staff and visitors have the potential to be affected by this deficient practice. The facility has now conducted testing on all nonhospital-grade electrical receptacles in all resident room	01/05/2024

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	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 12/13/23 between 9:00 a.m. and 3:45 p.m. with the Maintenance Supervisor present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles for the past 12 month period or prior. Based on interview at the time of record review, the Maintenance Supervisor said electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. He further said he could not find documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period. Based on observations on 12/13/23 between 4:50 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Supervisor, there were at least four to six electrical receptacles in each resident room. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)		locations. No issues were identified. The facility will continue to conduct annual testing of all nonhospital-grade electrical receptacles in resident rooms and document the results of the tests for review by the authorities. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now conducted testing on all nonhospital-grade electrical receptacles in all resident room locations. No issues were identified. The facility will continue to conduct annual testing of all nonhospital-grade electrical receptacles in resident rooms and document the results of the tests for review by the authorities. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the regulation related to the testing of nonhospital-grade electrical receptacles. The maintenance supervisor has been educated on their responsibility to ensure that this annual test is performed and the findings documented for review by the authorities. *The corrective action taken to monitor to ensure the deficient*	

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			practice will not recur is that the administrator and/or assistant administrator will now be reviewing annually the documentation of the testing of the nonhospital-grade electrical receptacles in resident rooms to ensure that the tests are performed in accordance with the regulation. Any concerns identified will be promptly discussed with the maintenance supervisor for immediate correction.	
K 0000 Bldg. 03	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: 12/13/23 and 12/14/23 Facility Number: 000300 Provider Number: 155539 AIM Number: 100287340 At this Life Safety Code survey, the small house health facility at Bertha D Garten Ketcham Memorial 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,	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective January 19, 2024 to the state findings of the Life Safety Code Recertification State Licensure Survey and Emergency Preparedness Survey conducted on December 14, 2023.	

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	Life Safety Code (LSC), Chapter 18, New Health Care Occupancies. This one story facility was 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, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 10 certified beds and had a census of 10 at the time of this survey. The main building of the facility has a capacity of 62 and had a census of 38 at the time of this survey. Combined, the facility has a capacity of 72 and had a census of 48 at the time of this survey. Quality Review completed on 12/21/23			
K 0291 SS=C Bldg. 03	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review and interview, the facility failed to ensure there was complete documentation for the testing of 1 of 1 battery backup light that was tested monthly for 30 seconds during the past 12 months. LSC 18.2.9.1 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	K 0291	K 291 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. There is now documentation to support that all battery-operated backup lights have been tested for at least thirty seconds, including the battery	01/04/2024

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	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 12/13/23 between 9:00 a.m. and 3:45 p.m. with the Maintenance Supervisor present, the facility did have a preventative maintenance (PM) report that the battery powered emergency light set at the generator was tested monthly, however, the monthly PM was not complete. The monthly test indicated the battery powered emergency light set was only tested for 15 seconds, furthermore, there were no monthly tests performed during March, September, and November of 2023. Based on an interview at the time of record review, the Maintenance Supervisor agreed the PM form for the battery powered emergency light set was not complete and confirmed there were three months where the light set was not tested. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)		backup light located at the generator. The facility will now consistently test all battery-operated backup lights monthly and document all required components of the testing including the 30 second testing period. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. There is now documentation to support that all battery-operated backup lights have been tested for at least thirty seconds, including the battery backup light located at the generator. The facility will now consistently test all battery-operated backup lights monthly and document all required components of the testing including the 30 second testing period. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on their responsibility to ensure that monthly testing of all battery-operated backup lights is being conducted and documented in accordance with the regulation. The documentation shall include the 30 second testing period. *The corrective action taken to*	

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			monitor to ensure the deficient practice will not recur is that the administrator and/or assistant administrator will now review monthly the preventative maintenance documentation on the testing of the battery-operated backup lights to ensure that all documentation has been completed accurately and in accordance with the regulations. Any concerns identified will be promptly reviewed with the maintenance supervisor so that immediate corrective action can be taken.	
K 0321 SS=F Bldg. 03	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)			

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	c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 2 rooms with fuel fired equipment was protected with a complete 1-hour fire-rated barrier. This deficient practice could affect all residents, staff, and visitors in the Rose House. Findings include: Based on observations on 12/13/23 between 3:45 p.m. and 4:40 p.m. during a tour of the facility with the Maintenance Supervisor, there was a room in the attic that contained two fuel fired furnaces. The walls in this room were protected with a 1-hour fire-rating barrier, except, the east wall that separated the furnace room from the remainder of the attic space. There was no drywall on the back side of this wall, and there was only one 5/8 inch layer of drywall on the furnace side of this wall, which does not meet the 1-hour fire-rating barrier requirement. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the lack of a 1-hour fire-rated wall in the Rose House attic fuel fired furnace room. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23.	K 0321	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified all residents and staff in the physical therapy gym have the potential to be affected by this deficient practice. A self-closing device has now been placed on the physical therapy storage room door and is functioning properly. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents and staff in the physical therapy gym have the potential to be affected by this deficient practice. A self-closing device has now been placed on the physical therapy storage room door and is functioning properly. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the regulation	01/04/2024

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	3.1-19(b)		related to the requirements of hazardous storage areas. The maintenance supervisor was instructed that it is their responsibility to ensure that the regulations are being followed to ensure the proper safety/security is maintained in the hazardous storage areas. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a housewide audit of all areas of the facility has been conducted to identify each hazardous storage room to ensure that these areas are being maintained in accordance with the regulation including self-closing devices on the doors. These doors will be monitored in accordance with the regulation as part of the facility's preventative maintenance program to ensure that the self-closing device is in place and functioning properly.	
K 0345 SS=F Bldg. 03	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance			

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	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 documentation was available to show that all smoke detectors were sensitivity tested within the past 24 months or prior. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the	K 0345	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors of the Rose House have the potential to be affected by this deficient practice. The facility has now conducted sensitivity testing on all smoke detectors and there is documentation on file for review by the authorities of this testing. The facility will continue to ensure that the smoke detectors have a sensitivity test completed at least every 24 months as required by the regulation. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors of the Rose House have the potential to be affected by this deficient practice. The facility has now conducted sensitivity testing on all smoke detectors and there is documentation on file for review by the authorities of this testing. The facility will continue to ensure that the smoke detectors have a sensitivity test completed at least every 24 months as required by the regulation. *The measures that have been put into place to ensure that the*	01/04/2024

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	detector. This deficient practice could affect all residents, staff, and visitors in the Rose House. Findings include: Based on record review on 12/13/23 between 9:00 a.m. and 3:45 p.m. with the Maintenance Supervisor present, the facility was unable to produce a smoke detector sensitivity report for all smoke detectors during the past 24 month period or prior. Based on interview at the time of record review, the Maintenance Supervisor said he thought the fire alarm system vendor did perform a smoke detector sensitivity test in the Rose House, but confirmed there was no smoke detector sensitivity testing documentation available. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)		*deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the regulation related to the sensitivity testing requirements of smoke detectors. The maintenance supervisor was instructed on their responsibility to ensure the smoke detector sensitivity testing is completed every 24 months and documentation of this testing retained on file for review by the authorities in accordance with the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the administrator and/or assistant administrator will now be reviewing the documentation on the sensitivity testing of the smoke detectors in the Rose House every 24 months to ensure that the documentation has been completed timely. Any concerns identified will be promptly discussed with the maintenance supervisor for immediate corrective action.	

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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
K 0373 SS=F Bldg. 03	NFPA 101 Subdivision of Building Spaces - Accumulation Subdivision of Building Spaces - Accumulation Space Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2 Based on observation and interview, the facility failed to ensure space was provided on each side of the smoke barrier to adequately accommodate the total number of residents from the adjoining compartment. 18.3.7.5.1 states not less than 30 net feet per resident shall be provided within the aggregate area of corridors, resident rooms, treatment rooms, lounge or dining areas, and other low hazard areas on each side of the smoke barrier. This deficient practice could affect all 10 residents, staff, and visitors in the Rose House. Findings include: Based on observations on 12/13/23 between 3:45 p.m. and 4:40 p.m. during a tour of the facility with the Maintenance Supervisor, the facility was provided with three separate smoke compartments, however, two of the smoke compartments did not meet the requirements of 18.3.7.5.1. One smoke compartment was on the west side of the house and contained commercial laundry equipment with fuel fired equipment, and was not provided with an exit to the outside. The other smoke compartment was the garage which was also on the west side of the house. The garage was full of combustible items including; Against the east wall, two sets of shelving full of cardboard boxes, totes, plastic, paper, and other house hold general storage; Against the west	K 0373	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents staff and visitors have the potential to be affected by this deficient practice. The smoke compartment identified as being located on the west side of the house that contains commercial laundry equipment with fuel fired equipment is not utilized as an evacuation route. The smoke compartment identified as the garage has now been cleaned out and all items removed. The garage is not and will not be utilized as a storage area. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents staff and visitors have the potential to be affected by this deficient practice. The smoke compartment identified as being located on the west side of the house that contains commercial	01/06/2024

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	wall, cardboard boxes, totes, old furniture, and other house hold general storage. In the middle of the garage were tables and chairs. Based on interview at the time of observation, the Maintenance Supervisor said the garage was considered a smoke compartment, but was also used for storage purposes. He said the tables and chairs were not normally in the middle of the garage, but they had had a Christmas party for the residents recently. He also said there was never a vehicle parked in the garage. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)		laundry equipment with fuel fired equipment is not utilized as an evacuation route. The smoke compartment identified as the garage has now been cleaned out and all items removed. The garage is not and will not be utilized as a storage area. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the regulation related to subdivision of building spaces accumulation. The maintenance supervisor was educated on their responsibility to ensure that no items are being stored in the garage smoke compartment. Monthly audits of the garage will be conducted by the maintenance supervisor as part of the facility's preventative maintenance program to ensure no items are being stored in this area. The maintenance supervisor will document these monthly audits and the findings. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the administrator and/or assistant administrator will monitor the documentation monthly of the audits conducted to ensure no items are being stored in the garage area.	

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K 0711 SS=F Bldg. 03	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of 38 of 38 residents in the Main Building to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 18.7.2.2. LSC 18.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 18.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the	K 0711	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey all residents, staff and visitors have the potential to be affected by this deficient practice. The facility fire safety plan has now been amended to include the location of the smoke barriers within the facility. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility fire safety plan has now been amended to include the location of the smoke barriers within the facility.	01/05/2024

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	required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's "Fire Plan" on 12/13/23 between 9:00 a.m. and 3:45 p.m. with the Maintenance Supervisor and Assistant Administrator present, the plan did address evacuation of the smoke compartment, however, the plan did not identify where the smoke barriers were located in the facility. Based on interview at the time of record review, the Maintenance Supervisor and Assistant Administrator acknowledged and agreed that the Fire Plan did not identify where the smoke barriers were located in the facility. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)		*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for administration and the maintenance supervisor on the regulation related to the requirements of a fire safety, evacuation and relocation plan. Administration and the maintenance supervisor were educated on their responsibility on ensuring that all components of the regulation are outlined in the facility's fire safety plan. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the facility's fire safety plan will be reviewed by the Quality Assurance committee at least bi- annually to ensure that all components of the regulation are outlined in the facility's fire safety plan. Modifications to the fire safety plan will be made when warranted or required by regulation.	
K 0712 SS=C Bldg. 03	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			

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	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. 18.7.1.4 through 18.7.1.7 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 3 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 12/13/23 between 9:00 a.m. and 3:45 p.m. with the Maintenance Supervisor present, 3 of 4 second shift (evening) fire drills were performed between 7:03 p.m. and 7:51 p.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the times the second shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b) 3.1-51(c)	K 0712	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now conducted fire drills on each shift at times that are varied by at least two hours of the prior fire drill being conducted. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now conducted fire drills on each shift at times that are varied by at least two hours of the prior fire drill being conducted. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the regulation related to conducting fire drills at varied times. The maintenance	01/05/2024

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			supervisor was instructed that fire drill must be conducted at staggered hours with at least a two-hour time difference from the previous fire drill that was conducted on that shift. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* fire drill reports will now be reviewed by the administrator and/or assistant administrator monthly to ensure that the time frame of each fire drill is staggered by at least two hours from the time the previous fire drill that was conducted on that shift. Any concerns identified will be discussed with the maintenance supervisor so that immediate action can be taken to correct.	
K 0761 SS=F Bldg. 03	Based on record review, observation, and interview; the facility failed to ensure a complete annual inspection and testing of 1 of 1 stairway fire door assembly, and 1 of 1 oxygen transfilling room door assembly was completed in accordance with LSC 18.1.1.4.1.1. Communicating openings in dividing fire barriers required by 18.1.1.4.1 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	K 0761	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey all residents, staff and visitors have the potential to be affected by this deficient practice. The form utilized to document the annual inspection and testing of smoke barrier and fire rated doors has been amended and now contains documentation	01/04/2024

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	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 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.		for the inspection of the door assemblies. All smoke barrier and fire rated doors have now been inspected/tested and there is documentation to support these inspections/testing including documentation of the inspection of the door assemblies. These inspections also included the stairway fire door and the door to the oxygen transferring room. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. All smoke barrier and fire rated doors have now been inspected/tested and there is documentation to support these inspections/testing including documentation of the inspection of the door assemblies. These inspections also included the stairway fire door and the door to the oxygen transferring room. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the regulation related to the maintenance, inspection and testing of smoke barrier and fire rated doors. The maintenance supervisor was educated on the required documentation that must be included with each inspection in	

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	(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. Findings include: Based on record review on 12/13/23 between 9:00 a.m. and 3:45 p.m. with the Maintenance Supervisor present, the facility did provide documentation of a form used for the annual inspection of all of the facility's smoke barrier and fire rated door assemblies, however, the documentation provided was not filled out to prove the fire door assemblies were inspected. Based on interview at the time of record review, the Maintenance Supervisor said the documentation provided was the only inspection and testing documentation available for the annual inspection/testing of the facility's fire door assemblies. Based on observations during a tour of the facility with the Maintenance Supervisor between 3:45 p.m. and 4:40 p.m., there were 2 stairway fire door assemblies noted in the facility. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference. 3.1-19(b)		accordance with the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the administrator and/or assistant administrator will now be reviewing annually the documentation on the maintenance, inspection and testing of smoke barrier and fire rated doors. Administration will ensure that the documentation includes the inspection of the door assemblies in accordance with the regulation.	
K 0914 SS=F Bldg. 03	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.			

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	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 one 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 complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia 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	K 0914	*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents staff and visitors have the potential to be affected by this deficient practice. The facility has now conducted testing on all nonhospital-grade electrical receptacles in all resident room locations. No issues were identified. The facility will continue to conduct annual testing of all nonhospital-grade electrical receptacles in resident rooms and document the results of the tests for review by the authorities. *The corrective action taken for the other residents that have the*	01/05/2024

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	ounces). This deficient practice could affect all residents. Findings include: Based on record review on 12/13/23 between 9:00 a.m. and 3:45 p.m. with the Maintenance Supervisor present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles during the past 12 month period. The most recent documentation available was dated 02/15/22. Based on interview at the time of record review, the Maintenance Supervisor said electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. He further said he could not find documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period. Based on observations on 12/13/23 between 3:45 p.m. and 4:40 p.m. during a tour of the facility with the Maintenance Supervisor, there were at least four to six electrical receptacles in each resident room. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23. 3.1-19(b)		*potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now conducted testing on all nonhospital-grade electrical receptacles in all resident room locations. No issues were identified. The facility will continue to conduct annual testing of all nonhospital-grade electrical receptacles in resident rooms and document the results of the tests for review by the authorities. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the regulation related to the testing of nonhospital-grade electrical receptacles. The maintenance supervisor has been educated on their responsibility to ensure that this annual test is performed and the findings documented for review by the authorities. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the administrator and/or assistant administrator will now be reviewing annually the documentation of the testing of the nonhospital-grade electrical receptacles in resident rooms to ensure that the tests are performed in accordance with the regulation. Any concerns	

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			identified will be promptly discussed with the maintenance supervisor for immediate correction.	