STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT FRANKLIN	580 LEMLEY STREET FRANKLIN, IN 46131

(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: 06/07/23 Facility Number: 000352 Provider Number: 155442 AIM Number: 100290720 At this Emergency Preparedness survey, Hickory Creek at Franklin was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 36 certified beds. At the time of the survey, the census was 29. Quality Review completed on 06/08/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.**	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Spall	HFA	06/20/2023

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

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

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator, the Maintenance Director and the Field Maintenance Supervisor from 9:20 a.m. to 1:00 p.m. on 06/07/23, the following was noted: a. weekly emergency generator inspection documentation for 13 weeks of the most recent twelve month period was not available for review. Weekly emergency generator inspection documentation for the 13 week period of 10/03/22 through 12/31/22 was not available for review. b. monthly load testing documentation for the facility's LP gas fired emergency generator for the two month period of November 2022 and December 2022 was not available for review. c. thirty-six month period emergency generator testing documentation for four continuous hours for the facility's LP gas fired emergency generator was not available for review. Based on observations with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 1:45 p.m. on 06/07/23, the facility has one LP gas fired emergency generator located outside the building on the north side of	E 0041	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The supplemental 4-hour load testing was performed on 6/19/23 and is available for review. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be negatively impacted when the generator was not tested appropriately. Corrective action was to run the 4 hour load test and to educate the Maintenance Supervisor. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director was educated on 4-hour load testing requirements by ED on 6/20/23. The maintenance director will verify the thirty-sixth month period emergency generator 4 hour load testing is completed based on the preventative maintenance schedule.	06/20/2023

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	the property. Based on interview at the time of record review, the Field Maintenance Supervisor agreed weekly generator inspection documentation and monthly load testing documentation for the aforementioned weekly and monthly periods was not available for review and agreed supplemental load testing documentation for four hours within the most recent three year period was also not available for review. These findings were reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ="" span="">**By what date the systemic changes will be completed: 6/20/23** **Compliance Date = 6/20/23**	
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: 06/07/23 Facility Number: 000352 Provider Number: 155442 AIM Number: 100290720 At this Life Safety Code survey, Hickory Creek at Franklin was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K 0000		

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	This one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and has battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 29 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility storage services were sprinklered except for one detached garage which was not sprinklered. Quality Review completed on 06/08/23			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation and interview; the facility failed to document annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) 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, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered.	K 0291	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Emergency Battery Lighting test was completed and properly documented on 6/14/23. **How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents could potentially be affected by emergency lighting not	06/20/2023

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	(4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (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, staff and visitors. Findings include: Based on review of Direct Supply TELS "Emergency Lighting: Conduct a 90 minute operational test" documentation dated 12/30/22 with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during record review from 9:20 a.m. to 1:00 p.m. on 06/07/23, the results of annual functional testing documentation for all battery operated light locations in the facility for the most recent twelve month period was not available for review. The aforementioned documentation did not state the results of annual 90-minute testing for each battery light location in the facility. Based on interview at the time of record review, the Maintenance Director and the Field Maintenance Supervisor stated the facility has a total of four battery operated lights, annual 90-minute testing was completed at the end of 2022 but agreed the results of annual 90-minute testing for each battery operated light location in the facility within the most recent twelve month period was not documented. Based on observations with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 1:45 p.m. on 06/07/23, a total of four battery operated lights were noted in the facility and each battery operated light illuminated when its respective test button was pushed.		working properly. Corrective Action taken was to complete the annual emergency battery powered lighting test and to educate our Maintenance Supervisor. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director or designee will test all emergency lighting for 90 minutes now and annually to ensure it is operating properly and document appropriately in TELS. ED will do a TELS documentation audit monthly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Supervisor was provided education on emergency battery light testing and frequency thereof by ED on 6/19/23. **By what date the systemic changes will be completed: 06/20/23** **Compliance Date: 06/20/23**	

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	These findings were reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 1 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during a tour of the	K 0372	**K372** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Penetration caused by conduit was repaired by Maintenance Supervisor on 6/13/23 using fire rated caulk. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:**	06/20/2023

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	facility from 1:00 p.m. to 1:45 p.m. on 06/07/23, three separate two inch in diameter open ended conduits penetrated the smoke barrier wall above the suspended ceiling above the corridor door set by the Visitor's Restroom by Room 13. Each conduit contained a blue water line which passed through the smoke barrier wall. Each conduit was not firestopped on the north side of the smoke barrier wall. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned openings in the smoke barrier wall above the corridor door set by Room 13 were not firestopped to maintain the fire resistance rating of the smoke barrier wall. These findings were reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		All residents could be potentially affected by there being a hole in the smoke barrier wall. Corrective action taken was to repair the wall, do a whole house audit of smoke barriers and potential penetrations, and to audit the smoke barrier walls monthly to ensure that they are intact. Whole house audit was completed on 6/20/23. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Supervisor was educated on smoke barrier construction and how to maintain the smoke barrier walls in our building on 6/19/23 by ED. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Maintenance Supervisor will perform audit of smoke barrier walls now and every month x 12 months to ensure they are intact. This will be added to our facility Preventative Maintenance Log. **By what date the systemic changes will be completed: 6/20/23** **Compliance Date = 6/20/23**	
K 0712 SS=F	NFPA 101 Fire Drills			

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Bldg. 01	Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the second shift for 1 of 4 quarters and on the third shift for 2 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS: "Fire Drills" documentation with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during record review from 9:20 a.m. to 1:00 p.m. on 06/07/23, documentation of a fire drill conducted on the second shift in the fourth quarter (October, November, December) 2022 was not available for review. In addition, documentation of a fire drill conducted on the third shift in the third quarter (July, August, September) 2022 and in the first quarter (January, February, March) 2023 was also not available for review. Based on interview at the time of record review, the Administrator and the Field Maintenance Supervisor stated the facility operates three shifts per day and agreed documentation of a fire drill conducted on the second and third shifts in the aforementioned	K 0712	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Monthly Fire Drills will be completed and documented per tentative schedule by Maintenance Director or designee 1 x monthly. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken**: All residents have potential to be affected by lack of fire drills being completed. Corrective Action was to complete fire drill and educate the Maintenance Supervisor. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Executive Director will audit monthly by the 25th of every	06/20/2023

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	calendar quarters was not available for review. These findings were reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Direct Supply TELS: "Fire Drills" documentation with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during record review from 9:20 a.m. to 1:00 p.m. on 06/07/23, first shift fire drills conducted within the most recent twelve month period on 07/27/22, 01/27/23 and on 04/11/23 were conducted at, respectively, 2:00 p.m., 1:15 p.m. and 1:51 p.m. Based on interview at the time of record review, the Administrator and the Field Maintenance Supervisor stated the facility operates three shifts per day and agreed the aforementioned first shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		month x12 months to ensure fire drills are documented and completed per schedule. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Maintenance Director was educated in the use of TELS to assist with monitoring monthly fire drills on 6/19/23 by ED. The Executive Director will review TELS with the Maintenance Supervisor once a month to ensure fire drills occurred and are documented appropriately. **By what date the systemic changes will be completed: 06/20/23**	

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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 record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was available for review in accordance with NFPA 99. 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 shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1	K 0914	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Annual receptacle testing was completed on 6/14/23. **How other residnets having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:**	06/20/2023

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	states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on record review with the Administrator, the Maintenance Director and the Field Maintenance Supervisor from 9:20 a.m. to 1:00 p.m. on 06/07/23, annual electrical receptacle inspection and testing documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Field Maintenance Supervisor agreed electrical receptacle inspection and testing documentation within the most recent twelve month period was not available for review. Based on observations with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 1:45 p.m. on 06/07/23, most recent sleeping rooms have non-hospital grade receptacles installed in the rooms with some resident sleeping rooms having a mix of hon-hospital grade and hospital grade receptacles		All residents have the potential to be affected by the lack of an annual receptacle test. Corrective Actions taken were to complete the Annual Receptacle test and to educate the Maintenance Supervisor. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Executive Director or designee will confirm that the receptacle testing was completed each year by completing an audit. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Maintenance Supervisor was educated on the receptacle testing procedure to complete the receptacle testing annually and where to document in Tels by ED on 6/19/23. Tels audit will be done monthly by ED/or designee. **By what date the systemic changes will be completed: 6/20/23** **Compliance Date = 6/20/23**	

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	installed in the room. These findings were reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels			

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	and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the facility's emergency generator was maintained for 13 weeks of the most recent 52 week period. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS "Emergency Generators Exercise Generator (with no load)" documentation with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during record review from 9:20 a.m. to 1:00 p.m. on 06/07/23, weekly emergency generator inspection documentation for 13 weeks of the most recent twelve month period was not available for review. Weekly emergency generator inspection documentation for the 13 week period of 10/03/22 through 12/31/22 was not available for review. Based on interview at the time of record review, the	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 4 hour load testing was completed by Maintenance Director on 6/20/23. Weekly and Monthly testing performed per schedule. **How other residents having the potential to be affective by the same deficient practice will be identified and what corrective action will be taken:** All residents had the potential to be affected by the generator not being tested properly. The Corrective Action taken was to run the load test and to educate the Maintenance Supervisor on generator tests and documentation. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Supervisor was educated on Generator Testing and documentation procedure for weekly, monthly and every 36 month testing by ED on 6/19/23.	06/20/2023

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	Maintenance Director and the Field Maintenance Supervisor stated the facility has one LP gas fired emergency generator and agreed weekly inspection documentation for the aforementioned 13 week period was not available for review. These findings were reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to document emergency generator monthly load testing for 2 months of the most recent 12 month period to meet the requirements of NFPA 110, Standard for Emergency and Standby Powers Systems, 2010 Edition, Chapter 8.4.2. Section 8.4.2 states diesel generator sets shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Documentation will be reviewed monthly by the Administrator/or designee on the 28th of the month x 12 months **By what date the systemic changes will be completed: 6/20/23** **Compliance Date = 6/20/23**	

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	residents, staff and visitors. Findings include: Based on review of Direct Supply TELS "Emergency Generators Test Generator Under Load" documentation with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during record review from 9:20 a.m. to 1:00 p.m. on 06/07/23, monthly load testing documentation for the facility's LP gas fired emergency generator for the two month period of November 2022 and December 2022 was not available for review. Based on interview at the time of record review, the Maintenance Director and the Field Maintenance Supervisor agreed monthly load testing documentation for November 2022 and December 2022 was not available for review. These findings were reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b) 3. Based on record review, observation and interview; the facility failed to document 36 month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1			

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	states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator, the Maintenance Director and the Field Maintenance Supervisor from 9:20 a.m. to 1:00 p.m. on 06/07/23, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's LP gas fired emergency generator for the facility was not available for review. Review of the emergency generator inspection contractor's preventative maintenance documentation dated 02/21/22, 08/23/22 and 02/06/23 indicated the manufacturer's nameplate rating for the generator was rated at 25 kW. Based on interview at the time of record review, the Field Maintenance Supervisor stated supplemental load testing documentation for four hours within the most recent three year period was not available for review. Based on observations with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 1:45 p.m. on 06/07/23, the facility has one LP gas fired emergency generator located outside the building on the north side of the property. These findings were reviewed with the Administrator, the Maintenance Director and the			

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	Field Maintenance Supervisor during the exit conference. 3.1-19(b)			