STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155763	A. BUILDING -- B. WING	01/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/21/20 Facility Number: 011296 Provider Number: 155763 AIM Number: 200827620 At this Emergency Preparedness survey, North Ridge Village Nursing & Rehabilitation 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 77 certified beds. At the time of the survey, the census was 43. Quality Review completed on 01/23/20	E 0000		
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.			

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

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	The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.			
	Based on record review and interview, the facility failed reviewed and updated the Emergency Preparedness Plan (EEP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency EEP	E 0004	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** how other residents having the potential to be affected by the	02/20/2020

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	with the Administrator and Maintenance Director on 01/21/20 at 11:00 a.m. and at 3:00 p.m. , no documentation could be provided to show the EEP was reviewed and updated annually. Based on an interview during records review, the Administrator stated the EEP has been reviewed in the last year but could not find the documentation to show the EEP was reviewed annually.		same deficient practice will be identified and what corrective action(s) will be taken; **All residents residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. Emergency Preparedness Policy and Procedure was reviewed on 1/17/2019. Emergency Preparedness Policy and Procedure will be reviewed and up-dated if warranted.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance Director was re-educated regarding annual review of the Emergency Preparedness Plan. The facility's Emergency Preparedness Plan will be reviewed and up-dated as warranted. The Emergency Preparedness Plan annual review will be added to the facilities QAPI meeting agenda to occur in January of each preceding year.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Maintenance Director or designee will monitor the**	

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			Emergency Preparedness Plan annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has been achieved for three consecutive reviews and plan will be adjusted accordingly.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures (b) Policies and procedures. [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. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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 annually. *[For ESRD Facilities at §494.62(b):] Policies			

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	and procedures. The dialysis facility 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 These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to annually review and update the Emergency Preparedness Plan (EPP) policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review of the facility's EEP with the Maintenance Director and Administrator on 01/21/20 at 11:30 a.m. and 3:00 p.m., no documentation was provided for review to show the EPP's policies and procedures were reviewed and updated annually. Based on an interview during records review, the Administrator stated the EEP has been reviewed in the last year but could not find the documentation to show the EPP's policies and procedures were reviewed annually.	E 0013	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** 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 residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. Emergency Preparedness Policy and Procedure was reviewed on 1/17/2019. Emergency Preparedness Policy and Procedure will be reviewed and updated as warranted by 2/20/2020.**	02/20/2020

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			what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance Director was re-educated regarding annual review of the Emergency Preparedness Plan. The facility's Emergency Preparedness Plan will be reviewed and updated as warranted by 2/20/2020. The Emergency Preparedness Plan annual review will be added to the facilities QAPI meeting agenda to occur in January of each preceding year.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Maintenance Director or designee will monitor the Emergency Preparedness Plan annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has been achieved for three consecutive reviews and plan will be adjusted accordingly.**	
E 0015 SS=C 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 [(b) Policies and procedures. [Facilities]			

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	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 every 2 years (annually for LTC). 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.			

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	(B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health 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 Plan (EPP) 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 records review of the facility's EEP with the Maintenance Director and Administrator on 01/21/20 at 11:40 a.m. and 3:00 p.m., the subsistence needs documentation for the emergency preparedness program was incomplete. Documentation for sewage and waste disposal outage was not available for review. Based on interview at the time of record review, the Administrator stated the sewer outage and waste disposal outage policies could not be found.	E 0015	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** 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 residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. Policy and Procedure for sewage and waste disposal outage has be implemented and added to the facility's Emergency Preparedness Plan.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance Director was educated over the implementation of the Policy and Procedure for sewage and**	02/20/2020

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			waste disposal outage. Policy and Procedure for sewage and waste disposal outage has be implemented and added to the facility's Emergency Preparedness Plan. 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 Director or designee will monitor the Emergency Preparedness Plan annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has been achieved for three consecutive reviews and plan will be adjusted accordingly.**	
E 0025 SS=F Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities [(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).] At a minimum, the policies and procedures must address the			

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	following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. Based on record review and interview, the facility failed to Emergency Preparedness Plan (EEP) include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include:	E 0025	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective	02/20/2020

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	Based on records review of the facility's EEP with the Maintenance Director and Administrator on 01/21/20 at 11:32 a.m. and 3:00 p.m., development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was not available for review during the time of survey. Based on an interview during records review, the Administrator stated the facility has identified places to go in the event of an evacuation but has not confirmed agreements with other LTC facilities. The Administration also stated, there were agreements with other LTC facilities made by the previous Administrator but did not know who the agreements were with or the location of the documentation.		action(s) will be taken; **All residents residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. North Ridge Village does have arrangements with other providers to receive residents in the event of limitations or cessations of operations. Written mutual aide agreements have been developed and are signed by North Ridge Village and receiving facility.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance Director was educated over the policy and procedure regarding mutual aid agreements. Written mutual aid agreements have been developed and are signed by North Ridge Village and receiving facility.** 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 Director or designee will monitor the Emergency Preparedness Plan annually ongoing and policy and procedures will be**	

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			up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has been achieved for three consecutive reviews and plan will be adjusted accordingly.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan (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). Based on record review and interview, the facility failed to annually review and update the Emergency Preparedness Plan (EPP) communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on records review of the facility's EEP with the Maintenance Director and Administrator on 01/21/20 at 11:30 a.m. and 3:00 p.m., no documentation was provided for review to show the EPP's communication plan was reviewed and updated annually. Based on an interview during records review, the Administrator stated the EEP has been reviewed in the last year but could not find the documentation to show the EPP's communication plan was reviewed annually.	E 0029	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** 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 residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. The facility's communication plan has been updated to include a method for sharing information and medical documentation for**	02/20/2020

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			residents to other LTC facilities. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance Director re-educated over the requirements of the facility's communication plan. The facility's communication plan has been updated to include a method for sharing information and medical documentation for residents to other LTC facilities.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Maintenance Director or designee will monitor the Emergency Preparedness Plan annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has been achieved for three consecutive reviews and plan will be adjusted accordingly.**	
E 0032 SS=C Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 482.15(c)(3), 483.475(c)(3), 483.73(c)(3), 484.102(c)(3), 485.625(c)(3), 485.68(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3) Primary/Alternate Means for Communication			

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NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

(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
	[(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).] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.			
	Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EPP) communication policy included (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c) (3). This deficient practice could affect all occupants. Findings include: Based on records review of the facility's EEP with the Maintenance Director and Administrator on 01/21/20 at 11:30 a.m. and 3:00 p.m., the EPP communication plan provided did not address primary and alternate means for communication. Based on interview at the time of record review, the Administrator stated the primary and alternate means for communication policy could not be found.	E 0032	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** 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 residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. The facility's communication plan has been updated to address primary and alternate means for**	02/20/2020

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			communication. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance Director re-educated over the requirements of the facility's communication plan. The facility's communication plan has been updated to address primary and alternate means for communication.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Maintenance Director or designee will monitor the Emergency Preparedness Plan annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has been achieved for three consecutive reviews and plan will be adjusted accordingly.**	
E 0033 SS=C Bldg. --	403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), 482.15(c)(4)-(6), 483.475(c)(4)-(6), 483.73(c)(4)-(6), 484.102(c)(4)-(5), 485.625(c)(4)-(6), 485.68(c)(4), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6)			

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	Methods for Sharing Information [(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).] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). Based on record review and interview, the facility	E 0033	what corrective action(s) will be	02/20/2020

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	failed to ensure the Emergency Preparedness Plan (EPP) communication policy included (4) A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.73(c)(4). This deficient practice could affect all occupants. Findings include: Based on records review of the facility's EEP with the Maintenance Director and Administrator on 01/21/20 at 11:30 a.m. and 3:00 p.m., the EPP communication plan did not include a method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care. Based on interview at the time of record review, the Administrator stated the method for sharing information and medical documentation for residents to other LTC facilities policy could not be found.		accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** 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 residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. The facility's communication plan has been updated to include a method for sharing information and medical documentation for residents to other LTC facilities.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance Director re-educated over the requirements of the facility's communication plan. The facility's communication plan has been updated to include a method for sharing information and medical documentation for residents to other LTC facilities.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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			program will be put into place; and **Maintenance Director or designee will monitor the Emergency Preparedness Plan annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has been achieved for three consecutive reviews and plan will be adjusted accordingly.**	
E 0034 SS=C 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 [(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).] The communication plan must include all of the following: (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			

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	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 Plan (EPP) communication policy 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). This deficient practice could affect all occupants. Findings include: Based on records review of the facility's EEP with the Maintenance Director and Administrator on 01/21/20 at 11:30 a.m. and 3:00 p.m., the provided EPP communication plan did not address 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. Based on interview at the time of records review and during exit conference, the Administrator looked through the EPP and could not find a plan that addressed a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance.	E 0034	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** 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 residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. The facility's communication plan has been updated to include a means for providing information about the facility's occupancy, needs, and its ability to provide assistance.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance Director re-educated over the requirements of the facility's**	02/20/2020

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			communication plan. The facility's communication plan has been updated to include a means for providing information about the facility's occupancy, needs, and its ability to provide assistance. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Maintenance Director or designee will monitor the Emergency Preparedness Plan annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has been achieved for three consecutive reviews and plan will be adjusted accordingly.**	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must			

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	develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):]			

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	Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an Emergency Preparedness Plan (EPP) training and testing program that is based on the emergency plan accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on records review of the facility's EEP with the Maintenance Director and Administrator on 01/21/20 at 11:30 a.m. and 3:00 p.m., the EPP did not include a training and testing program. Based on interview at the time of record review then again at the exit conference, the Administrator stated the facility has a training and testing program but was unable to locate the program.	E 0036	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** 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 residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. The facility's training and testing program has been added to the Emergency Preparedness Plan.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance Director educated regarding the facility's training and testing program. The**	02/20/2020

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			facility's training and testing program has been added to the Emergency Preparedness Plan. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Maintenance Director or designee will monitor the Emergency Preparedness Plan annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has been achieved for three consecutive reviews and plan will be adjusted accordingly.**	
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 *[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.			

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	(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 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			

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	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 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 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. (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			

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	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. (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			

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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
	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: Based on records review of the facility's EEP with the Maintenance Director and Administrator on 01/21/20 at 11:40 a.m. and 3:00 p.m., no documentation of annual EEP training, and no documentation to show staff could demonstrate knowledge of the EPP was available for review.	E 0037	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** 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 residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. The facility's training and testing program has been added to the Emergency Preparedness Plan.** what measures will be put into place and what systemic changes will be made to ensure that the	02/20/2020

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	155763	A. BUILDING -- B. WING	01/21/2020

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	Based on an interview at the time of records review, the Administrator stated documentation of annual staff EPP training could be found..		deficient practice does not recur; **Maintenance Director educated regarding the facility's training and testing program. The facility's training and testing program has been added to the Emergency Preparedness Plan.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Maintenance Director or designee will monitor the Emergency Preparedness Plan annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has been achieved for three consecutive reviews and plan will be adjusted accordingly.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/21/20 Facility Number: 011296 Provider Number: 155763 AIM Number: 200827620	K 0000		

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NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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	At this Life Safety Code survey, North Ridge Village Nursing & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility is separated from an attached non-certified Residential Care Facility by a Fire Wall with a 2-hour fire resistance rating. The facility has a capacity of 77 beds with a census of 43 at the time of this survey. All areas where residents have customary access were sprinklered. The facility does have a garage providing facility services that was not sprinklered. Quality Review completed on 01/23/20			
K 0324 SS=E 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,			

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	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 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 use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 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 staff in the kitchen and 25 residents in the dining room. Findings include: Based on observation with the Maintenance Director on 01/21/20 at 12:33 p.m., the kitchen was provided with a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the Cook was asked; what is the correct response if there was a grease fire underneath the hood. The employee replied; grab the grease extinguisher. The employee failed to indicate activating the UL 300 hood extinguishing system and using the K-class fire extinguisher for a hood grease fire. The Maintenance Director acknowledged the Cooks response and stated all kitchen staff will be informed on proper response.	K 0324	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** 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 residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. All kitchen staff educated regarding the use UL 300 hood system.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance Director and Dietary Manager educated over**	02/20/2020

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	3.1-19(b)		**the need to ensure kitchen staff are periodically re-educated over the use of the UL 300 hood system. All new hires for the kitchen will be educated during orientation regarding the UL 300 hood system ongoing. Dietary Manager/Designee to educate all kitchen staff regarding the UL 300 hood system quarterly on-going. Maintenance Director/Designee to educate all staff annually regarding the UL 300 hood system ongoing.** 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 Director to monitor UL 300 hood system training quarterly for 4 quarters, then annually thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI Committee monthly on-going in which plan will be adjusted accordingly.**	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained			

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	in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on record review with the Maintenance Director and Administrator on 01/21/20 at 10:32 a.m., no documentation could be provided regarding a visual semi-annual fire alarm system inspection six months after the annual fire alarm inspection conducted in May of 2019. Based on interview at the time of record review, the Maintenance Director stated a visual semi-annual fire alarm inspection six months after the annual fire alarm inspection was not completed.	K 0345	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** 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 residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance Director will be re-educated over the requirements for semi-annual visual inspection of the fire alarm system. A log titled "Semi-Annual Visual Fire Alarm Inspection" has been initiated.** how the corrective action(s) will be monitored to ensure the	02/20/2020

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	3.1-19(b)		deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Maintenance Director/Designee will visually inspect required areas of the fire alarm system semi-annually. Documentation will occur on the "Semi-Annual Visual Fire Alarm Log" at the time the inspection is completed. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI Committee monthly on-going in which plan will be adjusted accordingly.**	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants.	K 0346	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** how other residents having the potential to be affected by the	02/20/2020

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	Findings include: Based on records review with the Maintenance Director and Administrator on 01/21/20 at 11:10 a.m. and 3:00 p.m., the fire watch plan for impaired fire alarm systems failed to include contacting the monitoring company and the Indiana State Department of Health (ISDH) via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided did not state contacting the monitoring company and ISDH via the Gateway link or at the e-mail address listed above in the event the fire alarm system has to be placed out of service for four or more hours. 3.1-19(b)		same deficient practice will be identified and what corrective action(s) will be taken; **All residents residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. Fire watch plan has been updated to include notification of the monitoring company and ISDH gateway.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance Director educated over requirements of the facility's fire watch plan. Fire watch plan has been updated to include notification of the monitoring company and ISDH gateway.** 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 Director or designee will monitor the Fire Watch Plan annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has been achieved for three consecutive reviews and plan will be**	

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			adjusted accordingly.	
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 Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 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. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director and Administrator on 01/21/20 at 10:32	K 0353	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** 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 residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. A 5-year**	02/20/2020

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	a.m., no documentation for an internal inspection of the sprinkler piping was available for review. Based on interview at the time of record review, the Maintenance Director stated the documentation for an internal pipe inspection could not be found and was unsure when the last internal inspection was conducted 3.1-19(b)		**internal pipe inspection was completed on 7/29/2015. Documentation of inspection has been obtained and placed in fire alarm system logbook.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Maintenance Director re-educated regarding fire alarm inspection requirements. A 5-year internal pipe inspection was completed on 7/29/2015. Documentation of inspection has been obtained and placed in fire alarm system logbook.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Maintenance Director or Designee will monitor fire alarm inspection logs quarterly ongoing. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI Committee monthly on-going in which plan will be adjusted accordingly.**	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service			

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	Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility Findings include:	K 0354	what corrective action(s) will be accomplished for those residents found thave been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** 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 residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice. Fire watch plan has been updated to include notification of the monitoring company, insurance carrier, and ISDH gateway.** what measures will be put into place and what systemic changes	02/20/2020

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	Based on records review of the facility's EEP with the Maintenance Director and Administrator on 01/21/20 at 11:10 a.m. and 3:00 p.m., the fire watch plan for impaired sprinkler systems failed to include contacting the insurance carrier, monitoring company, and the Indiana State Department of Health (ISDH) via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided did not state contacting the insurance carrier, monitoring company, and ISDH via the Gateway link or at the e-mail address listed above in the event the sprinkler system has to be placed out of service for ten or more hours. 3.1-19(b)		will be made to ensure that the deficient practice does not recur; **Maintenance Director educated over requirements of the facility's fire watch plan. Fire watch plan has been updated to include notification of the monitoring company, insurance carrier, and ISDH gateway.** 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 Director or designee will monitor the Fire Watch Plan annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has been achieved for three consecutive reviews and plan will be adjusted accordingly.**	
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			

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NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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	switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1	K 0918	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.** 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 residing in the facility have the potential to be**	02/20/2020

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	155763	A. BUILDING 01 B. WING	01/21/2020

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	generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review with the Maintenance Director and Administrator on 01/21/20 at 11:32 a.m., documentation of a four hour run test conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Maintenance Director stated a four hour continuous run was not conducted in the past 36 months. 2. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director and Administrator on 01/21/20 at 11:33 a.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the Maintenance Director stated the facility does have a diesel generator. The Administrator stated the generator contractor did		**affected. No residents will be affected by this alleged deficient practice.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **A 4-hour run test was conducted on 1/28/2020 for the facility's diesel generator. The facility did have an annual fuel quality test performed for the diesel generator on 10/14/2019. Results of fuel quality test have been obtained and have been added to the generator logbook. Maintenance Director has been re-educated regarding generator inspection requirements.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Maintenance Director or Designee will monitor generator inspection logs weekly on-going. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI Committee monthly on-going in which plan will be adjusted accordingly.**	

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	take a fuel sample but could not find the report that showed the result of the fuel test. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 3 flexible cord power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice can affect 5 residents in the therapy gym. Findings include:	K 0920	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents will be affected by this alleged deficient practice.**	02/20/2020

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	Based on observations during a tour of the facility with the Maintenance Director on 01/21/20 at 12:03 p.m., there were three power strips in use in the therapy gym where resident care was provided. One power strip met 1363A, but the other two power strips did not meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed two power strips were in use in a resident care area and did not meet 1363A or 60601-1. 3.1-19(b)		how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents residing in the facility have the potential to be affected. No residents will be affected by this alleged deficient practice.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Power strips have been removed from the therapy gym. Staff re-educated on power cord and extension cord usage on February 10, 2020 at all staff meeting.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Maintenance Director or Designee will monitor all areas of the facility for use of power strips 2 times a month times 3 months, then monthly times 3 months, then quarterly thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI Committee monthly on-going in which plan will be**	

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			adjusted accordingly.	